

The 'Kidstime' intervention for children of parents with mental illness: An exploration of the experience of the 'Kidstime' workshops and relevant school-based support.

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I certify that all material in this thesis which is not my own work has been identified and that no material has previously been submitted and approved for the award of a degree by this or any other University.

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Abstract

The overall aim of this research was to explore the support needs and experiences of children of parents with mental health needs (COPMHN) and their families, in order to inform future support. This research involved two linked phases, both employing qualitative methods. In phase 1 I aimed to explore participants' and facilitators' experiences of the 'Kidstime' intervention for families where a parent has a mental illness (Our Time Foundation, 2019). This phase focused on the aims and impact of the intervention and the school-linked nature of the referral process. Semi-structured interviews were undertaken with children, parents and facilitators involved in the Kidstime intervention.

In phase 2 I explored the support available in schools for COPMHN. Focus groups were carried out with secondary school children who had experienced parental mental health needs to explore their perceptions of support. Interviews with special educational needs coordinators (SENCOs) working in primary schools were also undertaken to gain their views on the needs of COPMHN and the availability of support.

Interviews were analysed in accordance with Braun and Clarke's (2006) stages of thematic analysis. The findings highlight the success of the Kidstime intervention in fulfilling the aims set out by the Our Time Foundation (2019). Findings suggest that the intervention has a positive impact on the families in attendance in the following ways: improved communication and understanding in relation to mental illness, improved social relationships and reduced isolation, reduced stigma, a positive impact on mental health and a positive impact on family relationships.

This research highlights schools as well-placed to identify and support children experiencing parental mental health needs, but also recognises barriers to support and the need for increased involvement from other specialist services. This research also considers the role of the educational psychologist (EP) in relation to the growing responsibilities of school staff to promote and support the mental health of vulnerable children in educational settings.

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List of abbreviations

Abbreviation	Definition
ACE	Adverse childhood experiences
COPMHN	Children of parents with mental health needs
COPMI	Children of parents with mental illness
CPN	Community psychiatric nurse
CQC	Care Quality Commission
DfE	Department for Education
EP	Educational psychologist
FAPMI	Families where a parent has mental illness
FLO	Family liaison officer
PSA	Parent support adviser
SCIE	Social Care Institute for Excellence
SENCo	Special educational needs coordinator
TA	Teaching assistant
WHO	World Health Organisation

Chapter 1: Introduction

1.1 Contextual Relevance

1.1.1 Increased focus on mental health

In recent years, there has been increasing interest in the promotion of mental health and wellbeing, due to its implications for health and functioning at an individual and societal level (Stewart-Brown & Shrader-McMillan, 2011). Due to an increased awareness and acceptance of mental health difficulties, the scale of the unmet need is becoming clearer (Baker, Farmer & Winstanley, 2017).

The UK government have prompted an increased focus on mental health, with recent publications including 'Public Mental Health' (Public Health England, 2018) and 'Mental Health and Behaviour in Schools' (Department for Education (DfE), 2018) highlighting the need for more effective identification of, and support for, those experiencing poor mental health. However, within such publications there is often a lack of reference to preventative intervention for those known to be at risk of developing mental health needs. One of these 'at risk' groups is children experiencing parental mental illness (Reupert, Maybery & Kowalenko, 2012).

Research indicates that 10 to 15% of children in the United Kingdom live with a parent who has a mental illness (Henshaw, Adshead & Bende, 2011). This figure only includes parents with diagnosed mental illnesses and therefore the number of children affected is likely to be much higher. Research suggests that around 29% (50,000 children) of young carers care for someone with a mental health problem (Dearden & Becker, 2004).

Many children of parents with mental health needs (COPMHN) are able to function well and achieve in life, if their parents receive the right support at the right time (Hogg, 2013). However, there is a recognition that a parent's mental illness can adversely affect their children in a variety of ways, most notably, there is a tendency for an intergenerational persistence of mental health difficulties (Johnston, Schurer & Shields, 2013). COPMHN are at an increased risk of developing a range of physical, emotional, behavioural and psychological problems themselves (Felitti et al., 1998; Reupert, Maybery & Kowalenko, 2012; Sachs-Ericsson, Sheffler, Stanley, Piazza & Preacher, 2017). Poorer life

outcomes and an adversely affected developmental trajectory are major concerns highlighted in the literature (Henshaw et al., 2011; Nicholson, Nason, Calabresi & Yando 1999; Oates, 1997; Reupert et al., 2012). Parental mental illness can also impact on educational opportunities, especially when children are also young carers (Falkov et al., 2016).

Given the prevalence of parental mental health needs and the potential impact of this on children, identification and support is important, in order to mediate some of the aforementioned difficulties and negative outcomes.

1.1.2 Support for children of parents with mental health needs

Despite the prevalence of parental mental health needs and the vast literature on the potential impact of this for children (Reupert & Maybery, 2016), there is little research exploring the support available for COPMHN. Often these children are not in contact with children's mental health services as there are thresholds to be met, and hence access to such services relies on the child already having difficulties of their own (Cooklin, 2010). Support offered by such services is therefore reactive, rather than preventative. For those children that do reach a threshold for mental health support services, around 70% have not had appropriate intervention at an early age (The Children's Society, 2008a).

In adult mental health services, there is often a lack of consideration of the impact of a patient's mental illness on their ability to parent, and hence family sensitive support is not offered (Maybery & Reupert, 2009; The Children's Society, 2008a). Maybery and Reupert (2009) highlight a lack of family and child-friendly policies and procedures in some adult mental health services, as well as a lack of knowledge and skills in relation to children and parenting.

Research suggests that school-based mental health interventions have the highest likelihood of reaching vulnerable children and highlights school staff as well-placed to educate and offer support to vulnerable children and families (Kern et al., 2017; Sanders, Jackson & Thomas, 1996). However, there has been a paucity of research investigating the capacity of school-based staff to support COPMHN and their families (Bibou-Nakou, 2004). The little published research available suggests that there is a lack of recognition by school staff of the familial environment of children, and where children *are* identified as

vulnerable, staff are uncertain of how to address the situation (Bruland et al., 2017).

1.1.3 The Kidstime intervention

The Kidstime intervention was developed by a group of professionals led by Family Psychiatrist Dr. Cooklin to provide an explanation-based, whole-family intervention aimed at developing children's resilience to parental mental illness (Our Time Foundation, 2017). There are now around 15 Kidstime workshops running in the UK, predominantly in London, with a few more established internationally. These groups run once a month, and are facilitated by a wide range of professionals, most often from health services. Vulnerable families are often identified and referred to these groups via mental health and social care support services.

The Kidstime intervention is for families where the parent has a mental illness and their family. The Kidstime intervention aims to: support children to better understand mental illness; promotes resilience and supports families to tackle concerns or challenges. The workshops aim to support families to better recognise and understand their own needs and the impact of these on other family members (Our Time Foundation, 2019).

There are a wide range of mental health needs evident in Kidstime sessions, though there is not a criteria or threshold for these needs that parents must meet. It is however a necessary requirement that parents openly recognise and acknowledge that their mental health needs are adversely affecting their relationship with their child or are having an impact on their child's development.

The workshops generally begin with a short period of 'settling in' as families arrive, and drinks and refreshments are provided. There is then a 'warm up' game, to promote enjoyment and relaxation. This is followed by the 'seminar' section of the workshop, where there is explanation or discussion around a particular theme relating to mental illness. Often themes to be discussed arise from previous discussion, guided by the facilitators. Adults and children then split into separate groups. In the individual groups, attendees will often share stories about family life and discuss current situations/difficulties, often in relation to the seminar theme. There is often an opportunity in this section to

take part in creative activities, allowing both adults and children to express their thoughts and feelings in various ways. The groups then come back together to feedback about their discussion and activities and share pizza together. The workshops then finish with a game to signify the end of the session and promote positive feelings for families before leaving the workshop.

1.1.3.1 Kidstime in Southbridge

Kidstime workshops in the local authority of Southbridge operate a unique school-linked referral system, rather than health and social care-linked referrals and facilitation as in all other Kidstime workshops. Kidstime workshops in Southbridge run fortnightly and take place in a centrally-located building, with attendees travelling to the site from surrounding schools.

Facilitators of the Southbridge workshops include the following professionals; A teacher, a psychotherapist, an educational psychologist, a family support worker and a learning mentor. All of these professionals are employed by the multi-agency support team in Southbridge. Lead facilitators in Southbridge have received training from The Our Time Foundation. The multi-agency team is funded based on buy-in from primary schools, with certain professionals seconded from the local authority. Schools that subscribe to the multi-agency service are able to access the Kidstime intervention for children in their schools.

In Southbridge, children are identified by school staff as experiencing some kind of negative impact, that is thought to be related to their parent's mental health needs. Support for these children is then requested from the multi-agency support team in Southbridge. This team consists of educational psychologists, psychotherapists, systemic family therapists, counsellors, family support workers and learning mentors. The team also has links to health via a clinical psychologist who is present at panel meetings. At the multi-agency support panel, requests for support are discussed and it may then be deemed appropriate to make a referral to Kidstime. These referrals are then followed up by a member of the team to assess the suitability of the families for Kidstime workshops.

The Our Time Foundation also promotes the 'Who cares?' programme, a school-based psychoeducation package designed to raise awareness in

relation to parental mental illness; reduce stigma and create a supportive environment for children whose parents experience mental illness (Our Time Foundation, 2019). This programme is currently established in one secondary school in Southbridge.

A small-scale piece of research has been carried out on the Kidstime intervention to explore the value of the workshops as perceived by the families involved (Wolpert, Hoffman, Martin, Fagin & Cooklin, 2015). This was based on a health-based referral model, whereby referrals come from health and social care services, and where workshops are led by health care professionals. This piece of qualitative research was analysed using thematic analysis to build a picture of the benefits and limitations of the intervention from the perspectives of the attendees. From this, five key themes emerged; initial engagement, sharing with others, learning about mental health, opportunity for fun and impact on family relationships. This research begins to build a picture of the value of Kidstime as experienced by those receiving the intervention.

It is important to recognise that this piece of research was carried out by professionals involved in the initial development of the Kidstime programme. It is therefore important to consider researcher bias and acknowledge that those conducting the research may have had a vested interest in reflecting the most positive aspects of the intervention. This research sought to investigate the benefits and limitations of the Kidstime intervention, rather than explore in-depth the mechanisms by which the intervention benefits participants. This research did not take in to account the views of the facilitators involved, who may have valuable insight in to the benefits for some of the attendees that the attendees themselves may not yet be able to recognise or verbalise. In discussion of their findings, the researchers themselves recognised the need for a more rigorous evaluation of the Kidstime workshops. It is also important to consider that Kidstime workshops operating a health-based referral model will often miss vulnerable children as a result of themselves or their parents not currently being known to mental health or social care services.

The nature of mental illness itself can often prevent people from seeking help (Bruland, Lenz & Wahl, 2017). Those who *are* able to access Kidstime are arguably the more resilient and aware parents who have been able to overcome

both physical and psychological barriers to seek help and attend the workshops. It is therefore important to consider what support is available for those children whose parents are currently unable to access such interventions.

1.2 Personal Relevance

In my current role as a trainee educational psychologist, I have been involved in supporting COPMHN. In my experience, when there are mental health needs within the family, there is an added layer of complexity in planning appropriate support. I have supported the Kidstime intervention in Southbridge for over a year, supporting parents with mental illnesses and their children. I have noticed that when children first come to Kidstime, there is sometimes confusion and a lack of understanding around mental illness, despite its seemingly overwhelming presence in their everyday lives. I reflect on the impact of this on a child's development, recognising that sometimes these children intermittently experience the loss of their parent as someone to depend on, and to rely on for emotional containment. I was therefore interested in exploring the support available for this vulnerable group in both community and school-based contexts.

1.3 Professional relevance – The role of the educational psychologist

Educational psychologists (EPs) can play an important role in promoting positive mental health in schools, as well as empowering schools to respond to arising needs and vulnerable groups (DfE, 2010; Kinderman, 2017). Cane and Oland (2015) discuss the importance of EP involvement for both targeted and universal interventions including supporting staff in relation to mental health understanding and awareness, supporting staff to involve parents and supporting schools to overcome practical constraints. Psychologists have a wide range of skills allowing them to work with other services at an early intervention level. These skills include; recognising when children may be vulnerable, being aware of thinking biases in problem-solving and decision-making, applying their knowledge and training in mental health and applying their knowledge of interventions promoting resilience (Rouf, 2014).

EPs support vulnerable groups of children on a regular basis, both directly and through those in the child's immediate and extended systems (Ashton & Roberts, 2006). COPMHN are considered to be one of these vulnerable groups

(Felitti et al., 1998), hence the views of these children, their families and other professionals involved are relevant to inform EP practice.

The government response to the green paper 'Transforming Children and Young People's Mental Health Provision' highlights next steps in supporting the mental health of children and young people (Department of Health and Social Care & DfE, 2018). This document focuses predominantly on reactive approaches to mental health, with EPs mentioned rarely, despite their necessary presence in each and every school. I would suggest that EPs are well placed to support intervention at a preventative level for groups known to be at risk.

1.4 Thesis overview and structure

This study comprises of two related phases focusing on the support needs of COPMHN. The overall aim of this research is to explore the needs and experiences of COPMHN, their families and supporting professionals in relation to the support they have found to be effective and why. This is with a view to better understanding the support needs of this vulnerable group in order to inform future support in educational settings.

In the following sections of the thesis I will present relevant literature highlighting the significance of research in relation to support for COPMHN. Details of the methodology and methods employed in each phase are then provided. This is followed by the analysis, findings and discussion for each phase. A general discussion is then provided, in order to recognise the significance of the findings and their relevance to the profession of educational psychology and the wider context. Strengths and limitations of the research and future research directions will also be discussed.

Chapter 2: Literature review

This review is an exploration and evaluation of the literature regarding the impact of parental mental health needs on the children in these families and the support available to them. This review highlights a gap in the literature in relation to the mechanisms by which particular interventions such as 'Kidstime' have an impact, the nature of this impact and the way in which this population might best be supported within school-based contexts.

2.1 Literature searches

To assist in my review of the literature I used search engines within the Web of Science, Education Resource Information Centre, The British Education Index and Google Scholar. Searches conducted using the above databases covered a broad range of research within various fields including: education, psychology, psychiatry, mental health nursing and social work. Examples of journals reviewed as a result of my searches of the literature included: Clinical Child Psychology and Psychiatry, PsycINFO, Journal of Psychosocial Nursing, Educational Psychology in Practice, Research on Social Work Practice.

The search terms entered included variations of the following: parental mental health impact, children of parents with mental illness (COPMI), families where a parent has a mental illness (FaPMI), Kidstime, parental mental health intervention and support in schools, young carers' mental health. Searches were initially restricted to research published in the last 5 years, with some searches being extended to 10 years if a lack of published research was apparent. Within these papers, cited research papers of interest were also reviewed.

It is relevant to note that a great deal of the research in the area of parental mental illness and its impact is conducted in the field of psychiatry and psychology, whereby parents have diagnosed mental disorders. It is therefore important to consider the wider impact that parental mental health may have outside of clinical research parameters, where mental health needs may not reach a threshold for diagnosis and where needs may go undetected and unsupported.

Throughout this review, there is research relating to children of parents with a mental illness (COPMI) and children of parents with mental health needs (COPMHN). In the literature, it is difficult to distinguish the differential impact of mental health needs and mental illness, due to the varied nature of mental illness and its diagnosis. However, for the purposes of the current review, it is recognised that parental mental health needs and diagnosed mental illnesses may overlap, and that they both impact children in a similar way, albeit to differing degrees. It is acknowledged that the impact itself can be dependent on a number of risk and protective factors for both the parents and the children (World Health Organisation (WHO), 2014). For the purposes of this review, the terms 'mental health needs' and 'mental illness' will both be used to reflect the participant groups in the research discussed. 'Children of parents with mental health needs (COPMHN)' has been used to refer to children living with a parent that is part of either of these overlapping groups.

2.2 Definition and models of mental health

Mental health is defined as “a state of well-being in which an individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (WHO, 2001, p.1). Mental health is commonly recognised on a spectrum, from healthy to unwell (Centre for Mental Health, 2017). A number of models have been developed that attempt to conceptualise the development of mental health needs.

2.2.1 The Biopsychosocial Model

The Biopsychosocial Model proposed by Engel (1977) provides a framework for understanding the development of mental health and illness. This model proposes that mental health is based on a combination of biological, social and psychological factors (Engel, 1977). The Biopsychosocial Model offers a more holistic approach to health and illness in comparison to the traditional, biomedical view that attributes mental health disorders and illness to biological origins. However, the Biopsychosocial Model does not clarify the nature of the interrelationships between aspects of the model (Kinderman, 2005), with little

clarification of how psychological processes such as thoughts and feelings drive behaviour (Kinderman, Schwannauer, Pontin & Tai, 2013).

2.2.2 The Mediating Psychological Processes Model

The Mediating Psychological Processes Model (Kinderman, 2005) suggests an update to the Biopsychosocial Model (Engel, 1977), specifying that biological and physical abnormalities, social factors and circumstantial factors contribute to mental health due to their effect on psychological processes (Kinderman Sellwood & Tai, 2008). This model is applicable to understanding the intergenerational persistence of mental health difficulties (Johnston et al., 2013), in that the disrupted psychological processes of a parent with a mental illness might impact on the experiences and psychological processes of their children. Kinderman et al., (2008) discuss the idea that support services for mental health would be better placed within a 'social', rather than a 'medical' framework. Such support would take in to account the wider context on which mental health is based, recognising risk and protective factors and allocating support more holistically.

2.3 Impact of mental health needs on parenting

The majority of parents or carers with mental health needs can provide sensitive and consistent care for their children, if their own needs are well managed (Hogg, 2013). However, all forms of mental disorder in parents increase the risk of 'damaging' parenting behaviours, and abuse and neglect of their children (Felitti et al., 1998; Royal College of Psychiatrists, 2004; Stewart-Brown & Schrader-McMillan, 2011).

Mental illness can: compromise a parent's ability to care for their children, affect the way in which parents interact with their children and it can affect the amount of time spent with their children (Bronte-Tinkew, Moore, Matthews & Carrano, 2007; Oyserman, Bybee, Mowbray & Hart-Johnson, 2005; Pape & Collins, 2011; Rutter & Quinton, 1984). Some mental health needs may blunt emotions or result in inappropriate or harmful behaviour from the parent towards their child (Royal College of Psychiatrists, 2004). In rare cases of severe mental illness, parents may have delusions relating to their children, resulting in

unusual and sometimes threatening behaviour towards their children (Cleaver Unell & Aldgate, 2011). The general home environment can also be more negative for COPMHN in relation to family cohesiveness, expressiveness and conflict (Van Loon, Van de Ven, Van Doesum, Witteman & Hosman, 2014).

Brockington et al., (2013) posit the possible mechanisms by which the effects of mental health on parenting affect the children in the family. These include: parental preoccupation and emotional unavailability caused by symptoms of their illness and excessive, prolonged, and inappropriate anger directed at the child. Other 'damaging' behaviours include: impulsivity and extreme mood swings. Parental mental health problems can lead to parents that can be insensitive to their child's needs, unresponsive to their child's cues and who are more critical of their children (Cleaver et al., 2011). Research recognises that early relationship formation and attachment patterns are pathways negatively affected by parental mental health needs (Apter, Bobin, Genet, Gratier & Devouche, 2017; Cichetti, Rogosch & Toth, 1998; Hippwell, Goossens, Melhuish & Kumar, 2000; Toth, Rogosch, Sturge-Apple & Cichetti, 2009).

2.3.1 Attachment Theory

Attachment refers to the bond between care-giver and child which forms based on their interactions and experiences and affects the child's emotional and cognitive development (Bowlby, 1969). Secure attachments are based on sensitive and consistent responding to a child's needs. A secure attachment is associated with positive effects on emotional development and allows the child to develop a positive and healthy understanding of how to negotiate future relationships (Bowlby, 1969; 1988). Unpredictable, inconsistent or insensitive responding to a child needs signifies a lack of attunement between parent and child, which can result in an insecure attachment. This can have a negative impact on the emotional and cognitive development of the child and their ability to engage positively in future relationships and in other aspects of their lives (Bowlby 1969; 1988).

Given the aforementioned potential impact of mental illnesses on parenting, it is important to consider the impact that this may have on attachment. With parental depression and borderline personality disorders, research supports an

increased likelihood of a disrupted attachment to the child (Grace, Evindar & Stewart, 2003; Lyons-Ruth & Jacobvitz, 1999). However, it is important to bear in mind that some COPMHN may have developed attachments to other family members or adults, which may mediate some of the negative effects of an insecure attachment relationship with a parent with mental illness (Rutter, 1987).

2.4 Impact of parental mental health needs on children

When children experience environmental adversity or are inadequately stimulated early in life, this can have negative effects on a child's development and mental health, which can be enduring (Kahn, 2016). There are a number of negative impacts and outcomes for COPMHN outlined in the literature (Viganò et al., 2017). Household mental illness is recognised as an 'adverse childhood experience' (ACE) (Felitti et al., 1998). The ACEs study found a strong relationship between the breadth of exposure to ACEs and numerous risk factors for the leading causes of adult death (Felitti et al., 1998). ACEs are strongly linked to long-term negative effects on physical and mental health and wellbeing throughout one's lifetime (Sachs-Ericsson et al., 2017).

COPMI are at an increased risk of developing emotional, behavioural or psychological problems themselves (Reupert, Maybery & Kowalenko, 2012). When children are receiving treatment for their own mental health needs, research shows that around 80% of their parents have a mental illness (Naughton, Maybery & Goodyear, 2018). Parental mental illness is one of the strongest predictors of the development of psychopathology based on various genetic and environmental risk factors for children living in these families (Reupert et al., 2012). These children are more likely to present with an increased frequency of externalising and disruptive behaviours as well as anxiety and mood disorders (Keshavan et al., 2009; Pape & Collins, 2011). Anxiety disorders in parents have been associated with emotional and conduct problems, social phobia and separation anxiety, agoraphobia and obsessive-compulsive disorder in their children (Biederman et al., 2006; O'Connor, Heron, Golding & Glover, 2003). Children of depressed parents are three times more likely than children of non-depressed parents to develop depression, anxiety and substance dependence in adulthood (Weissman et al., 2006). Newman and

Stevenson (2005) also note increased impulsivity, an inability to name and modulate emotions and internalised negative self-attributions for COPMI.

Cooklin (2010) discusses some of the responses of children as a result of parental mental illness, these include: becoming dictatorial or bullying, self-blame and taking undue responsibility for problems in the family or for the illness itself, confusion around how to interpret their parent's behaviour, increased compliance in response to unpredictable environments, withdrawal and isolation, low self-esteem, depression, dissociation, violent and destructive behaviour and copying of parent's symptoms/behaviours. Murphy, Peters, Wilkes and Jackson (2016) conducted research with adults who had experienced parental mental illness in childhood, to examine the long-term effects of growing up in these circumstances. Participants reported feeling unsure of their own emotions, a loss of personal identity and an unclear sense of reality. These participants reported having felt that their own emotions were insignificant in relation to the emotional needs of their parents, leading to a lack of emotional awareness and emotional literacy. This research reinforces the importance of early intervention and family interventions that increase emotional literacy and promote resilience.

Further research suggests that 70% of COPMHN experience one or more of the following educational and social consequences: loss of education through poor attendance and emotional distraction, lower academic achievement, social isolation due to stigma and poor peer relationships (Cleaver et al., 2011; Henshaw et al., 2011; Nicholson et al., 1999; Oates, 1997; Royal College of Psychiatrists, 2012). Parental mental illness can also have a significant negative impact on a child's level of education, future household income and likelihood of a criminal conviction (Johnston et al., 2013). It is important to note that mental ill-health is a common feature of families living in adversity (Falkov et al., 2016), however these impacts were still apparent after controlling for socioeconomic factors and other aspects of health, with the authors highlighting a causal relationship.

The impact of parental mental health needs is also evident in relation to children entering care. Child social workers estimate that 50 to 90% of parents on their caseload have mental health problems or substance misuse issues (Office of the Deputy Prime Minister, 2004). In an analysis of serious case reviews, it was

found that parental mental health problems featured in 53% of cases (Sidebotham et al., 2016). Family conflicts, violence and negative life events are also associated with mental illness (Hosman, van Doesum & van Santvoort, 2009) and hence safeguarding is an important factor to consider in relation to support for COPMHN.

Another consequence of parental mental illness is that the children in these families may also become young carers (Bilsborrow, 2004). Caring responsibilities can significantly impact on a pupil's learning in the following ways: they may experience learning difficulties or miss school (Dearden & Becker, 2004), they are more likely to have lower educational attainment at GCSE level and are more likely than the national average to not be in education, employment or training (NEET) between 16 and 19 years old (The Children's Society, 2013). However, Cooklin (2010) highlights a danger of defining COPMHN as young carers without an acceptance of the additional impact of parental mental illness, stating that a young carer label alone "may provide a cloak of acceptability for allowing quite intolerable demands to be made on them" (p. 141). For young carers of parents with mental illness, caring needs may exceed emotional and cognitive maturity (Aldridge, 2006), highlighting the need for additional support to process and understand difficult experiences and associated feelings. Young carers of parents with mental health needs may have more significant needs than other young carers, due to the number of additional adverse experiences they are often exposed to and hence should be prioritised for interventions to build resilience and protect against adverse effects (Hayes & Spratt, 2009).

Mental illness can be erratic and unpredictable, which can be confusing, stressful and traumatic for the children in the family, particularly if they have caring responsibilities (The Children's Society, 2008b). Parents often recognise that children are more likely to develop mental illness because of their own illness. However, both parents and children report fear of interventions from professionals, predicting negative outcomes and a lack of consultation about their needs (The Children's Society, 2008a). Parents can also be concerned about accessing support services, due to the belief that they could be at risk of having their children removed from their care (Darlington & Feeney, 2009; Gray, Robinson & Seddon, 2008; Nicholson & Biebel, 2002). A lack of identification

and understanding of the needs of COPMHN and their families may lead to inappropriate and ineffective support.

2.5 Intervention and support

2.5.1 A lack of identification and awareness

Research suggests that only a small fraction of young carers receive the support they need (Children's Commissioner, 2016). It is likely that only a small proportion of these young carers are carers of a parent with a mental illness, particularly due to the nature of mental illness being under-identified, with only half of those who meet criteria being diagnosed (WHO, 2017).

Ofsted (2013) report that there are currently no national requirements to gather information about the number of parents/carers experiencing serious mental health difficulties. Ofsted (2013) report that family impact was not found to be an area of focus within adult mental health services generally. When risks to children relating to parental mental health needs were identified by adult mental health professionals, they were often not recognised early enough, and hence professionals had not been proactive in offering or signposting support (Ofsted, 2013; The Children's Society, 2008a).

The Children Act (2004) sets out the safeguarding responsibilities of all professionals working with children and families, with associated statutory guidance explicitly outlining the need for adult and children's services to work in collaboration. 'Working together to safeguard children' (Her Majesty's Government, 2015) is guidance based on the Children's Act (2004) and suggests that adult mental health services have a responsibility in safeguarding children when they become aware of, or identify, a child at risk of harm.

However, if there is a lack of focus on the family situation in adult mental health services as identified by Ofsted (2013), these services may not be primed to thinking systemically about the familial situation of a patient in their care, and therefore are less likely to identify a child at risk. The Social Care Institute for Excellence (SCIE) introduced guidelines relating to parental illness, promoting the message 'think child, think parent, think family' (SCIE, 2009), however there is a need for such guidance to be embedded and extended across services, as research suggests there are still missed opportunities in relation to support and

child protection due to a lack of holistic thinking and multi-agency support (Rouf, 2014).

A lack of collaborative working between adult and children's services has been highlighted as a contributory factor in serious case reviews (Ofsted, 2013). These serious case review reports highlight examples of parents' mental health needs being underestimated, affecting the support available to both the adult themselves and their family (Ofsted, 2013). Rouf (2014) discusses the problem of no single professional working with families in which there are mental health needs having an overview of the whole case, rather they just focus on their individual 'client'.

2.5.2 A lack of support for children of parents with mental health needs

The Care Quality Commission (CQC) (CQC, 2017; 2018) highlight that long delays for support and treatment are at further detriment to the mental health of children and young people. Due to funding and commissioning differences, health care services are often not working collaboratively with other relevant agencies, resulting in a lack of timely and appropriate support (CQC, 2017). Kahn (2016) highlights significant missed opportunities in changing the trajectory of mental health outcomes for vulnerable children and young people. This is supported by Kessler et al., (2005), who discuss a ten-year gap between the first onset of 'symptoms' relating to mental health needs and access to support.

Cooklin (2010) recognises the problem of COPMHN falling between the obvious responsibilities of relevant professionals and suggests that adult mental health staff and social workers often feel ill-equipped in terms of time and expertise to offer comprehensive support to children. Child and Adolescent Mental Health Services (CAMHS) are often under resourced and are required to give precedence to children with a defined disorder (Cooklin, 2010), which many of the COPMHN do not yet have. There is therefore a population who fall between the responsibilities of relevant professionals: children who do not yet have obvious difficulties of their own, and who have parents who do not access help for their mental health needs. These children may also have parents whose needs do not yet reach the threshold for support from adult mental health

services. This group of children may benefit from some preventative support. However, there appears to be a gap in provision in this area. It is unclear which services are capable of providing such support and what form this should take.

As a result of the CQC (2017) report on mental health services for children, a green paper was opened for consultation (Children's Commissioner, 2017). The document 'Supporting Mental Health in Schools and Colleges' (DfE, 2018) discusses the need for educational settings to promote positive mental health and identify and support pupils with emerging mental health needs. The document mentions the 'Mental Health First Aid' training programme that has recently been developed in an attempt to provide teachers and other professionals working with children and young people the skills and confidence to recognise the signs and triggers of mental health needs (Department of Health & DfE, 2017). This seems to be a positive step in the right direction in relation to mental health support for children and young people. However, the British Psychological Society (BPS) have argued that the current proposals focus on reactive, rather than preventative support, which fails to recognise the wider systems in which the individuals experiencing mental health difficulties are involved (BPS, 2018b), and hence misses valuable early-intervention opportunities to break the intergenerational cycle of mental health needs.

2.5.3 Identification and support for children of parents with mental health needs in relation to other vulnerable groups.

COPMHN make up the quieter majority of 'children in need' (Hayes & Spratt, 2009) and have been described as an "invisible, hidden and vulnerable workforce" who are isolated and stigmatised with restricted opportunities (Gray et al., 2008, p. 169).

A review of support services for vulnerable children by Ofsted and CQC (2013) suggested that the awareness of responsibility to identify vulnerable children and consider their needs was always stronger in drug and alcohol services than mental health services. The report highlights that most drug and alcohol services had systems in place to check if children were appropriately identified and their needs considered. However, in adult mental health services, most team managers did not have a system to identify which households had

children, did not monitor referrals to children's social care and did not systematically audit case record to ensure risks to children were considered.

Other research identified that the impact of parental mental illness on children can be much harder to comprehend for social care professionals, than other circumstances such as substance misuse and domestic abuse, and hence potential safeguarding issues are not identified as easily (Cleaver et al., 2011)

There are various support structures available for young carers themselves. Young carers include those who care for friends or family members who are ill, disabled, or who engage in substance misuse (Carers Trust, 2019). This can include COPMHN, however these children are not recognised as a distinct group in the UK, as in other countries, where they are identified as 'COPMI' and supported according to their additional and complex needs (Cooklin, 2010; 2015).

2.5.4 The need for preventative support

The above discussion emphasises the need for preventative support that recognises children 'at risk'. Such early intervention services could have an effect on the numbers of children being referred to CAMHS or prevent the escalation of difficulties whilst on the waiting list for more specialist services (Kern et al., 2017). As well as an extended focus on families in adult mental health services, there needs to be an extended focus in other settings to identify COPMHN whose parents may not even acknowledge they have a mental health need, may not have sought support, or do not reach a threshold for support from adult mental health services.

2.5.5 The need for collaborative, multi-agency working and a 'systems' perspective

Viganò et al., (2017) and Falkov (2012) highlight the need for a multi-agency approach to extending the knowledge, awareness and competences when working with families which have experienced parental mental illness, working collaboratively to make use of interdisciplinary initiatives. Rouf (2014) highlights that "inter-agency working is at the heart of child protection" and advocates for

an integrated overview of family functioning via good quality communication between the professionals supporting the families. More specifically, the author argues that more could be done to focus on early intervention for COPMHN, but this will require conversations between health and education that currently do not happen enough.

In order to work at a preventative level, there is a need for professionals working with children and families to adopt a 'systems' perspective (O'Hare, 2017). A systems perspective refers to the consideration of the wider context for an individual, and the way in which these wider systems may impact upon the individual concerned (Bronfenbrenner, 1979). This perspective advocates exploring the systems around a child to understand where difficulties may arise in order to consider appropriate support. Thinking holistically about the systems impacting on an individual is likely to lead to a need for multi-agency communication and collaboration, in order to access support for various individuals within a 'system'. However, research suggests that services relevant to COPMHN do not always work in collaboration to support them (Cooklin 2010; Foster, O'Brien & Korhonen, 2012; Katz & Hetherington, 2006). There is a need to look beyond individual service providers to develop a broader and more holistic perspective in relation to supporting vulnerable children and their families (Falkov et al., 2012; Owens, Crone, Kilgour & El Ansari, 2010).

2.5.6 School-based support

Staff working in the education sector may be able to offer relevant support to fill the support gap for early intervention in relation to mental health. Such professionals may include teachers, support staff and educational psychologists (EPs). Kahn (2016) reports that the commitment of the entire school workforce has been found to promote the best outcomes for children and young people in relation to mental health issues.

Research suggests that school-based mental health services have the highest likelihood of reaching vulnerable children (Kern et al., 2017). The structured environment that schools provide lends itself to early identification, prevention and intervention to prevent escalation of mental health needs (Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011). Tabak et al., (2016)

highlight schools as being well placed to offer support to families, provide counselling, nurture peer relationships and educate staff and students about mental health problems. Weist, Lovie, Lever, Johnson and Rowling (2002) support the positive outcomes of school-based support services for COPMHN, suggesting they can reach more children and adolescents with less stigma and provide greater access for families. School-based support can provide early intervention for COPMHN who do not yet meet the clinical criteria for specialist mental health services (Barrett & Turner, 2001). It is possible that early intervention might prevent the need for later responsive intervention commonly used in schools whereby school functioning and healthy development is significantly affected (Kern et al., 2017).

The latest 'Mental Health and Behaviour in Schools' guidance (DfE, 2018) recognises that school staff are not experts in mental health, whilst also discussing their role as front line mental health practitioners in a position to identify, intervene and signpost appropriately. There is very little research on the capacity of educational professionals to support the needs of the children experiencing parental mental health needs, or what form this support should take (Bibou-Nakou, 2004).

In relation to mental health needs generally, research by Mazzer and Rickwood (2015) suggests that school staff do not feel knowledgeable and skilled in dealing with mental health needs. Research by Bibou-Nakou (2003) suggests that although teachers can identify the risk and protective factors for children experiencing parental mental illness, there is a lack of early identification and support mechanisms in schools. The Bibou-Nakou (2004) study utilised focus groups comprising of experienced teachers to explore pre-determined topics relating to service planning and policy in the area of parental mental health needs. Results highlighted that teachers do not have the skills, knowledge or time to prioritise support for COPMHN due to a lack of support from their schools and time pressures. Although a valuable contribution to knowledge in the area of parental mental health from an education perspective, this research is dated and is relevant to the Greek education system at the time. The criticisms of focus groups discussed in the methodology chapter also apply to the Bibou-Nakou (2004) research, as this was the sole data collection method and hence the results should be considered with these criticisms in mind.

Recent research by Bruland et al., (2017) suggests that teachers struggle to identify vulnerable children and when they do, they are unsure how to approach the situation. It is therefore important to further explore the capacity of schools to identify and support vulnerable groups to ensure staff are equipped to deal with the level of need that they are expected to support. It is important to consider that the Bruland et al., (2017) findings are based on a small-scale review of the literature in the area of parental mental illness and awareness in schools, including only three pieces of research, each with a small sample size. The researchers themselves highlight that their review should be considered as an initial overview, suggesting the need for further research in this area.

2.5.7 Effective support: explanation, communication and family focus

Children generally tend to have low levels of mental health understanding due to a lack of accurate and non-stigmatised information (Riebschleger, Grove, Cavanaugh & Costello, 2017). Supporting COPMHN in understanding their parent's mental illness and behaviour can be a protective factor against future negative outcomes (Cooklin, 2010). Professionals supporting parental mental illness in families suggest that the following are important forms of support for COPMHN: clear and comprehensive psychoeducation, communication within and outside of the family about mental illness, support with coping strategies and access to relevant resources and interventions (Cooklin, 2010; Grove, Riebschleger, Bosch, Cavanaugh & van der Ende, 2017). Research by Power et al., (2015) found that open communication about mental illness when parents were unwell helped to build a greater sense of family connectedness and increased resilience.

Acri and Hoagwood (2014) emphasise the importance of children's mental health interventions having a component that recognises their parent's mental health needs, despite only finding a small number of interventions that did this. The authors suggest that research targeting support for family mental health is needed, recognising that treatment and planning for the family as a unit may have a significant impact on the outcomes for parents and children.

Interventions focusing on the parent-child dyad should be the target of attention when there are mental health needs within the family, rather than individual support (Apter et al., 2017; Falkov, 2012), with family-focused interventions

producing overall larger positive effects (Thanhäuser, Lemmer, de Girolamo & Christiansen, 2017).

When relationships in the child's environment are improved, the child's future resilience to mental illnesses is enhanced, even when there is prior history of mental illness in previous generations (Rutter, 2003; Tienari et al., 2004; Tienari, Wahlberg & Wyn, 2006). Family and relationship-focused interventions have demonstrated the potential to benefit all family members (Fadden & Heelis, 2011; Falloon, 2003) in the following ways: reducing the feeling of children's responsibility for parent's illness, preventing a negative impact on emotional well-being and reducing future costs to healthcare systems (Reupert & Maybery 2011).

Gatsou, Yates, Goodrich and Pearson (2015) emphasise that although research suggests family-based interventions are successful, not enough is known about the mechanisms by which they have an impact, highlighting a gap in the literature. These gaps in professional understanding suggest that children and families may not be receiving the most effective support (Charles, Reupert & Maybery, 2016).

2.5.8 Future of support for children of parents with mental health needs

The UK government is making positive progress by placing increasing emphasis on identification and support for children experiencing poor mental health (Children's Commissioner, 2017). However, as discussed, the current focus is more oriented to reactive approaches, promoting the identification of signs and symptoms of emerging or established mental health needs (BPS, 2018b), rather than focusing on prevention for groups known to be 'at risk'.

Wyn et al., (2000) discuss the temptation of schools to 'do' mental health education by bringing in a mental health expert, which is unlikely to have an impact on the wider school environment or a shift in whole-school thinking, as there is no relationship to ongoing whole-school processes. Professionals such as educational psychologists may be well placed to support teaching and intervention in relation to mental health support, as often they can be an integral part of the school system and in a position to "build bridges" between schools and the community (Farrell et al., 2006), whilst maintaining a holistic approach (Ashton & Roberts, 2006).

With the growing pressure on schools and colleges to support the mental health of pupils, it is important to recognise the opportunities for universal, whole-school teaching and identification. However, it is also important to recognise specific vulnerable groups that may benefit from early intervention. Wyn, Cahill, Holdsworth, Rowling and Carson (2000) support this idea, concluding that specific, targeted interventions provided within a whole school framework are likely to be most effective in supporting the needs of more vulnerable groups. Considering that parental mental health needs is a recognised ACE, and the previous research on the intergenerational impact of mental health, I suggest that COPMHN should be recognised as a target group for early intervention and support. It is however unclear whether schools currently have the capacity to identify these children and provide support for this vulnerable group.

2.6 Concluding comments

There has been a wealth of research on the negative impact of parental mental illness on children, however, there has been less research on children's experiences and perception of support services. It is important that the impact of family-focused interventions such as Kidstime are explored further, to understand the way in which such interventions have an impact. It is however important to recognise that due to the nature of mental health needs, engagement in whole family interventions is not always possible for some families. In circumstances where parents do not feel able to engage, it is important that there is still provision for the children living in these families, with schools being identified as well placed to offer this support. In understanding what works well in family-focused interventions such as Kidstime, aspects of good practice in relation to supporting COPMHN could be adapted to inform support in schools.

It is important to consider the current ability and capacity of school staff to support COPMHN, in order to highlight areas for development, highlight effective school-based practice already ongoing and establish a baseline with which to work from when considering next steps for support for this vulnerable group. The value of having a link professional such as an educational psychologist that can bridge the gap between school and community interventions to facilitate and extend support is also something to consider.

Chapter 3: Methodology

This chapter starts with the aims for all phases of the current research and the corresponding research questions. This is followed by my philosophical assumptions, including ontological and epistemological perspectives. I will then discuss the methods employed in the current research and the methods of data analysis. This chapter finishes with a description of the ethical considerations related to this research.

3.1 Research aims and questions

Phase 1

Aim: To explore the views of children, parents and facilitators involved in the Kidstime programme, under the school-based referral system in Southbridge, focusing on the impact of the workshops and the mechanisms by which this impact occurs.

Research question 1: How do participants' experiences of Kidstime align with the stated aims and objectives of Kidstime?

Research question 2: How do participants and facilitators of Kidstime view its impact?

Research question 3: How do participants and facilitators of Kidstime experience the process and context of the school-linked referrals?

Phase 2a

Aim: To explore the views of COPMHN in relation to their needs and the support they have received in school.

Research Question 4 - How do COPMHN perceive their additional social, emotional and mental health needs?

Research Question 5 - How do COPMHN perceive the support available to them in schools?

Research Question 6 - What support do COPMHN of secondary age think could be implemented for their group in schools?

Phase 2b

Aim: To explore the understanding and awareness of special educational needs co-ordinators in relation to the needs of COPMHN and the capacity for school-based support.

Research Question 7 - How are the needs of COPMHN perceived by school staff?

Research Question 8 - What support is currently available to support COPMHN in primary schools?

Research Question 9 - How do school staff feel support for COPMHN could be implemented in schools?

Research question 10 - What are the barriers to supporting COPMHN in schools?

3.2 Philosophical Assumptions

This section presents my philosophical position, which underpins my research design and approach. The ontological position of the current research aligns with the interpretivist assumption that reality is constructed by individuals, rather than the acceptance of one universal truth (Thomas, 2017). Social constructivism is my epistemological approach.

3.2.1 Interpretivism

The paradigm of interpretivism recognises that reality is constructed by individuals based on their perception of their experiences (Bryman, 1988; Thomas, 2017). Interpretivist research aims to elicit the 'understandings' that research participants have about a personally relevant topic, whilst the researcher aims to make sense of these understandings (Thomas, 2017). Within the paradigm of interpretivism, there is a recognition that there are multiple 'realities' that come together in a framework that is to be explored by the researcher (Thomas, 2017).

An interpretivist approach is relevant for the current research, as I was concerned with the 'reality' for children experiencing parental mental illness and

those who support them, rather than objective information about these groups. Interpretivism recognises that researchers themselves construct their own meaning in relation to participants' perceptions, whereby observations will be affected by ideas and assumptions and hence objective, value neutral research is not possible (Holloway & Wheeler, 2010; Ritchie et al., 2014). It is relevant to note that findings from interpretivist research cannot be assumed to be generalisable outside of the specific research setting, due to the recognition of the influence of context on the construction of reality (Thomas, 2017).

3.2.2 Social Constructivism

The current research is positioned in relation to the epistemology of social constructivism, based on my belief that knowledge is socially constructed by individuals. Social constructivism recognises the importance of culture and context in constructing knowledge (Kim, 2001), empowering the narratives of those with lived-experience. Social constructivism recognises that each of us has our own unique constructed version of reality, based on our experiences, and highlights that two people experiencing the same thing may not interpret it in the same way (Kim, 2001). Belief about the nature of the external world is not the same as belief about knowledge, therefore social constructivists *do* recognise a reality that exists outside of social construction but posit that socially constructed reality is the only reality that is meaningful (Crotty, 1998). This research aimed to give the participants an opportunity to voice their version of reality in relation to the current topic via in-depth interviews and focus groups. Based on my interpretation of the accounts of 'reality' gathered in the current research, common threads and themes were evident, revealing common perceptions of reality for the group members.

It has been debated how much knowledge is constructed within an interview interaction or how much it is a pre-existing phenomenon (Ritchie et al., 2014). Holstein and Gubrium (2004) posit that knowledge is constructed via the collaboration of researcher and interviewee. The authors state that "no matter how hard interviewers try to restrain their presence in the interview exchange... interviews are interactional accomplishments rather than neutral communicative grounds" (p. 150). Throughout the entire research process, I was aware that I have my own socially constructed version of reality which I recognise will have

affected the topic area of choice, the questions I chose to ask and the way in which I chose to ask them. Although I was considerate of such influences, I accept that they will have inevitably had an impact.

3.3 Exploratory qualitative research methods

Qualitative research is described as a “naturalistic, interpretive approach concerned with exploring accounts ‘from the interior’” (Flick, 2009). Such approaches focus on exploring ‘what, why and how’ questions, and uses the perspectives of those concerned as a foundation for understanding (Ritchie, Lewis, McNaughton-Nicholls & Ormston, 2014). The aim of qualitative research is to provide an in-depth and interpreted understanding of the social world as experienced by participants, and yields ‘rich’ data relating to emergent themes (Ritchie et al., 2014). Therefore, I chose a qualitative research design to align with my belief that knowledge is produced by exploring and understanding the perceptions of those for whom the topic is personally relevant and meaningful.

3.4 Phase 1 methods

3.4.1 Phase 1 sampling

Participants were recruited via opportunity sampling from the Kidstime workshops running in the Southbridge Local Authority. I had been volunteering my time at the workshops prior to planning my research, so I became familiar with both the attendees and facilitators. At each of the two workshop groups I spoke to the attendees and facilitators about my research ideas and provided those who were interested with a detailed information letter (Appendix K). I verbally followed up the letter in the next Kidstime workshop and arranged to meet with those who were willing to participate. In order to recruit children for the research, I first sent a letter to parents asking for their child’s permission to take part, and then sought further permission from the children themselves, after explaining the research in an age-appropriate manner, emphasising the voluntary nature of participation.

3.4.2 Phase 1 participants

The participants consisted of five Kidstime facilitators, five parents attending Kidstime, and four children (aged 6-11 years) attending the Kidstime workshops.

The five Kidstime facilitators had different professional roles outside of Kidstime including: a teacher, a psychotherapist, an educational psychologist, a learning mentor and a parent support adviser. All of these facilitators had been involved in the delivery of Kidstime for at least two years. All of the facilitators are also employed by the same multi-professional team in Southbridge. The participants included three female and two male participants.

All parents interviewed had a diagnosis of a mental illness. All parents interviewed for the research were female. One parent wished for her husband, who also attends the Kidstime workshops, to be present for the interview.

Of the children interviewed, three were female and one was male. I had originally recruited five children, however one child decided they did not want to take part on the day of interview.

The parents and children interviewed had all been attending Kidstime on a regular basis (at least four in every five scheduled workshops) for a minimum of a year.

3.4.3 Phase 1 Data Collection

For phase 1 I chose to employ the use of in-depth, semi-structured interviews. In-depth interviews are described as a powerful method for gaining descriptive information regarding people's interpretation of their social world (Ritchie et al., 2014). This method allows researchers to explore the perceptions of a particular group with knowledge and experience in relation to the topic of interest (Rubin & Rubin, 2012). Questions sought to capture the experiences of Kidstime attendees and facilitators in relation to the aims and impact of the intervention, as well as the nature of the school-based referral system. Interview schedules were generated based on the research questions previously outlined using the hierarchical focusing model (Tomlinson, 1989). This model allows the researcher to determine the general direction of questioning whilst giving space

and flexibility for the interviewee's perspective. The five stages of this model involve; outlining the structure and content of the research domain, identifying a research focus, devising a hierarchical framework for the interview, carrying out the interview in an open-ended, non-directive way using the interviewee's voice and finally transcribing and analysing. The concept map initially constructed to outline the structure and content of the research domain can be found in Appendix A. I chose to focus specifically on the support needs and experiences of COPMHN, rather than vulnerable groups more generally as I feel this group have a unique experience relating to their understanding of the complex nature and impact of mental illness. I also have a personal and professional interest in the needs of this group, as outlined previously.

Whilst developing the semi-structured interview schedule, I was cautious not to make assumptions about the group to be interviewed and checked all schedules with my research supervisors and colleagues. When conducting the interview itself, I first reminded the participants of the aims of the research and their rights as participants. I then proceeded to flexibly follow the interview schedule, beginning with open-ended questions on broader subject areas, narrowing down to more specific questions using probes, based on participants' responses.

I chose to use one-to-one interviews in order to create a confidential safe space for participants to feel able to talk openly. One-to-one interview techniques have been said to promote the development of trusting relationships, allowing the generation of rich data (Aldridge, 2006). Interviews were presented as more of a guided, informal discussion in order to put participants at ease. For children, language was adapted accordingly, and visual supports were provided in the form of a feelings scale, to support the children in relation to the questions about the impact of Kidstime. Research suggests that the use of visual representations can allow children to express themselves more effectively, than they might be able to verbally (Baker, 2015). Aspects of the children's interviews were focused on art work that they had created in the Kidstime workshops, to act as a stimulus for discussion. Children were also given the opportunity to draw, rather than verbally express their thoughts in relation to certain interview topics. All interviews were recorded to allow for accurate

transcription. Interview schedules for all phase 1 participants can be found in Appendix B.

I am aware that semi-structured interviews have some limitations and have previously discussed my understanding that knowledge is explored and constructed throughout the interview process, based on the interaction between myself and the interviewee and our prior knowledge and experiences.

Silverman (2011) argues that this is a 'narrow view' that denies the value of the interview data as saying anything about any other reality other than the interview itself. However, Ritchie et al., (2014) argues that such critiques are not relevant to robust qualitative research and maintain that methods such as semi-structured interviews can be used to effectively explore the constructions and experiences of research participants.

There is also the issue of interviewer bias, which, as discussed, I attempted to be aware of throughout the entire research process. Although involved in the delivery of Kidstime for a short while before conducting my research, I had an interest in exploring the genuine impact of the intervention and was open minded to the idea that the intervention may not have had an impact on the attendees.

After considering both the strengths and limitations of semi-structured interviews as a means of data collection, I deemed this to be the most suitable considering my research aims, questions and underlying philosophical approaches.

3.4.4 Phase 1 Data analysis procedure: Thematic Analysis

In order for data to be deemed trustworthy, data analysis must be done in a precise, consistent and exhaustive manner and recorded in a way that will allow others to recognise the analysis process as credible (Nowell, Norris, White & Moules, 2017). Thematic analysis (TA) was used to analyse all data collected in this research. I chose to use Braun & Clarke's (2006) stages of TA, as it is described as a useful method for examining the perspectives of different participant groups. It offers the opportunity to draw comparisons and recognise differences and allows the flexibility for identification of unanticipated topics and themes (Braun & Clarke, 2006; King, 2004).

After analysing the data collected, I felt that the data collected was rich enough to draw themes, recognising a saturation point whereby continued analysis fed into pre-established themes (Ritchie et al., 2014). The stages of thematic analysis according to Braun & Clarke (2006) include: transcription, reading and familiarisation, coding, searching for themes, reviewing themes and defining and naming of themes.

I have highlighted in detail the stages of thematic analysis undertaken in Appendix E, detailing my analysis alongside each stage, to demonstrate the trustworthiness of the data collected. Appendix F gives evidence of the reading and familiarisation stage of the analysis where handwritten notes were made. Appendix G gives examples of the process of coding. Appendix H shows how categories and themes were derived. Appendix I shows how global themes were defined and named. Codes, categories and themes derived from the raw data were triangulated with my research supervisors, to add to the trustworthiness of the themes generated (Nowell et al., 2017).

3.5 Phase 2a methods

3.5.2 Phase 2a Sampling

The children recruited for the focus groups were all from the one mainstream secondary school in Southbridge delivering the 'Who Cares?' programme. This is a psychoeducational programme designed to raise awareness of COPMI for school-based staff and children, promoting the understanding of and support for children experiencing parental mental illness. I chose to approach this school, as I felt the children were likely to have experienced support in relation to their circumstances and would therefore be able to offer some insight into their experiences. I contacted the school's headteacher via e-mail, and we arranged to meet in person. I presented my research ideas during our meeting and the headteacher agreed to provide participants for the research.

3.5.3 Phase 2a Participants

Through liaison with the headteacher and a member of pastoral staff at a secondary school in Southbridge, eight children were selected to take part in the research. Children were selected on the basis of having experienced

parental mental illness. Children from year 8 and year 11 were selected for the research. The year 8 children were selected as they had recently experienced eight weeks of teaching as part of the 'Who Cares?' programme. The year 11 students were selected as they were likely to have had the most experience of the school systems and support. Letters and consent forms (Appendix M) were sent out to parents via school staff and active parental consent was sought. I then sought further consent from the children themselves via a consent form (Appendix N), after explaining in detail the aims of the research, the nature of their potential involvement and their rights as participants. Those who returned the consent forms then took part in the research. The participants consisted of four children from year 8, and four children from year 11. The participants involved six female and two male participants.

3.5.4 Phase 2a data collection: Focus groups

Data was collected via two focus groups, a year 8 and a year 11 group. A focus group refers to "...a group of individuals selected and assembled by researchers to discuss and comment upon, from personal experience, the topic that is the subject of the research" (Powell & Single, 1996, p. 499). Focus groups are commonly used within qualitative evaluation research to discuss the bringing about of change for members of a group (Robson & McCartan, 2016). I chose to employ the use of focus groups as a data collection method for phase 2a of the current research, in order to elicit the views of secondary school pupils in relation to their needs, their perception of support and their contributions to future support. I was interested in individual contributions, group interaction, and the dominant realities as socially constructed within a group context (Frey & Fontana, 1991). I also felt that a focus group, rather than individual interviews, might put the children at ease in the unfamiliar situation, as there is less pressure on individuals to respond (Zikmund, 1997).

Understanding and explaining one's own attitude toward a topic can sometimes be easier against the backdrop of others' accounts and perspectives, which can also trigger additional material to discuss (Ritchie et al., 2014). The interaction between participants can also be useful when creative thinking, solutions and strategies are required (Ritchie et al., 2014), as is the case for research question 6 in phase 2a: What support do COPMHN of secondary age think

could be implemented for their group in schools? Groups present a more natural environment than that of individual interviews because participants influence, and are influenced by others, as they are in reality (Krueger & Casey, 2009). Group discussions reflect social constructions, normative influences, individual and collective identities and shared meanings (Ritchie et al., 2014), which can be interpreted in relation to the research questions. Zikmund (1997) posits that focus groups promote synergy, whereby the group process generates a wider range of information than could result from a similar number of in-depth interviews, often through the 'snowballing' of ideas.

Within the focus groups I stimulated the group discussion with topical questions in a semi-structured interview format, whilst allowing the participants to take the discussion to areas of interest. Interview schedules were constructed based on the research questions above using the hierarchical focusing model (Tomlinson, 1989), which has previously been outlined in this chapter.

I started the focus groups with a paired task, whereby children created a mind map of their understanding of mental illness. I chose to do this to ensure children had a reasonably accurate understanding of the concept of mental illness. This also served as an 'ice breaker' activity, to get the children talking to one another. Interviews took place within a large room in the children's school. Both focus groups lasted approximately an hour and were recorded to allow for transcription.

In choosing a data collection method I did consider the potential limitations of focus groups. It is argued that both dominant and reticent participants can limit the value of focus groups (Ritchie et al., 2014), however I ensured I was prepared to deal with such situations if required in order to allow for all group members to contribute. Another criticism relates to social influence, and the idea that participants often conform to a socially acceptable viewpoint (Ritchie et al., 2014). It is also argued that the interviewer has less control in the running of focus groups, as the participants interact and influence one another (Gibbs, 1997). I was also aware that bringing together a group of children who have experienced parental mental illness might have exposed the circumstances of some children to their peers. It was therefore not made clear to children that being a child of a parent with a mental illness was a prerequisite for their involvement.

Despite some of the limitations highlighted above, I felt that focus groups were the most appropriate method for gathering the views of COPMHN for phase 2a, based on my research questions and the time and practical constraints of the research project. The focus group stimulus questions can be found in Appendix C.

3.5.5 Phase 2a Data analysis procedure

Data was analysed using thematic analysis, using Braun & Clarke's (2006) model of thematic analysis summarised earlier in this chapter and detailed in Appendix E. Examples of the process of analysis can be found in Appendices F and G.

3.6 Phase 2b methods

3.6.1 Phase 2b sampling

The special educational needs coordinators (SENCOs) who took part in phase 2b of the current research were recruited via opportunistic sampling. I sent an e-mail to all primary school-based EPs within the Southbridge Local Authority, asking for their support in recruiting SENCOs to take part in my research. The e-mail contained a brief description of all phases of my research and the procedures for the SENCO's potential involvement. EPs forwarded this e-mail to SENCOs in their schools. The SENCOs who expressed an interest in taking part were then sent some additional, more detailed information about the research (Appendix O). I then arranged to meet with those who were willing to take part in order to conduct the interviews.

3.6.2 Phase 2b participants

The SENCOs were from primary schools within Southbridge Local Authority, apart from one from a neighbouring local authority. Those who were first to respond to my follow up e-mails were selected to take part in the research.

Consent forms were included at the bottom of the information letters originally sent out to SENCOs, which were signed and returned. The participants consisted of five SENCOs, all of whom were female.

3.6.3 Phase 2b data collection

In phase 2b I employed the use of semi-structured, in-depth interviews as described for phase 1. Again, interview questions were generated using the hierarchical focusing model (Tomlinson, 1989) outlined previously. For the interviews for phase 2b, relevant key findings from the prior research phases were presented as part of the interview schedule (Appendix D), in order to provide a stimulus for discussion. As with the previous interviews, participants were reminded of the aims of the research and their rights as participants before taking part in the interview. Interviews lasted between 40 minutes and an hour and were recorded to allow for transcription.

3.6.4 Phase 2b Data Analysis

Data was coded and analysed in line with the principles of thematic analysis (Braun & Clarke, 2006) outlined in Chapter 3 and detailed in Appendix E.

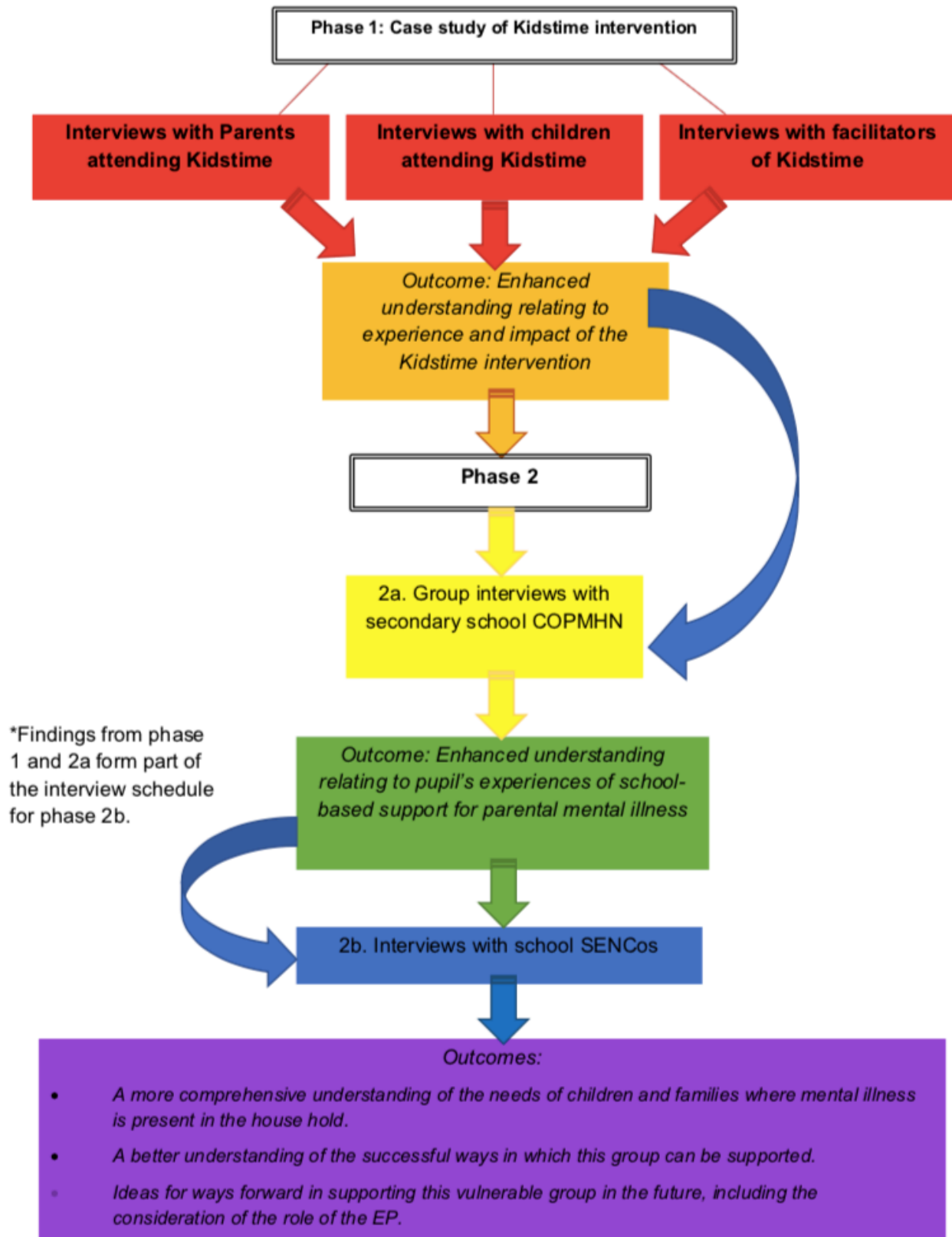
3.7 Quality Principles

I applied Yardley's (2000) validity principles to plan and undertake a quality piece of research. These include: sensitivity to context, commitment and rigour, transparency and coherence and impact and importance. My research reflects sensitivity to context in that I explored the relevant theoretical and empirical literature before planning and undertaking my research. I was sensitive to participants' perspectives of their experiences by asking open-ended questions and being led by their responses. My research approach demonstrates commitment and rigour as my data collection and analysis was systematic and thorough, as discussed below and outlined in Appendix E. I also engaged with the participants before undertaking my research to further develop my understanding of the participant group. This has been said to allow for the collection of richer data (Holloway & Wheeler, 2010). I have been transparent and coherent in the presentation of my analysis and have clearly explained how themes were derived from the data collected. This research has the potential to have an impact by contributing to and building upon the understanding of the support needs of COPMHN and their families.

3.8 Pictorial overview

Figure 1 below is a visual representation of the research phases and gives details of how they are linked.

Figure 1: *Pictorial overview of the current research*



3.9 Ethical Considerations

In accordance with the Code of Ethics and Conduct (British Psychological Society (BPS), 2018a) and the Code of Human Research Ethics (BPS, 2014), I planned this research considering the maximisation of benefit and minimisation of harm. I considered the wellbeing of the research participants at every stage of my research planning and execution, as well as others who could be affected in a negative way by my research. All participants were given pseudonyms to protect their identity in the write up of this research. Any names appearing in the transcripts were also changed. A pseudonym was also used for the local authority concerned.

3.9.1 Reducing potential harm

Risk is identified as a potential threat to a person's social status, privacy, values and beliefs, relationships and the disclosure of illegal behaviour (BPS, 2014). Risk of harm to participants was considered particularly carefully for the current research, due to the vulnerable nature of children and families experiencing parental mental illness. When interviewing participants for the research I avoided asking questions relating to mental health diagnoses and experiences, and instead focused on support experiences. My ethical proposal was considered at a higher-level panel of approval, due to the vulnerable nature of particular members of the participant population. Possible risks to participants were considered at the ethical application stage of this research. I completed a risk assessment detailing how potential risks would be managed. A copy of my approved ethics proposal and certificate confirming ethical clearance is available in Appendix J.

3.9.2 Consent

All participants were required to give active, informed consent for their participation in the research. Details of the mechanisms by which consent was sought for each phase are outlined in the chapters corresponding to those phases. Children involved in the research were required to have parental permission. Children were then asked to give their own permission, based on a child-friendly and age-appropriate discussion with myself, and the signing of a

simpler version of the consent form. The information provided to participants gave information regarding the voluntary nature of participation, confidentiality, anonymity and the right to withdraw their participation and data. Due to the mental health needs of some of the participants and the young age of others, I sought to check the participants understanding of what they had understood about the research as best as possible whilst emphasising their rights as participants.

Chapter 4: Phase 1

4.1 Phase 1 overview

Phase 1 was an exploration of the Kidstime workshops in Southbridge. I interviewed children, parents and facilitators of Kidstime using semi-structured interviews to explore the aims and impact of the workshops as perceived by attendees and facilitators. I also aimed to explore how the school-linked referral process and context is experienced. The participants included 5 parents, 4 children and 5 facilitators.

4.2 Research Aims and Questions

The research questions relevant to this phase are outlined below:

Research question 1: How do participants' experiences of Kidstime align with the stated aims and objectives of Kidstime?

Research question 2: How do participants and facilitators of Kidstime view its impact?

Research question 3: How do participants and facilitators of Kidstime experience the process and context of the school-linked referrals?

4.3 Phase 1 Findings

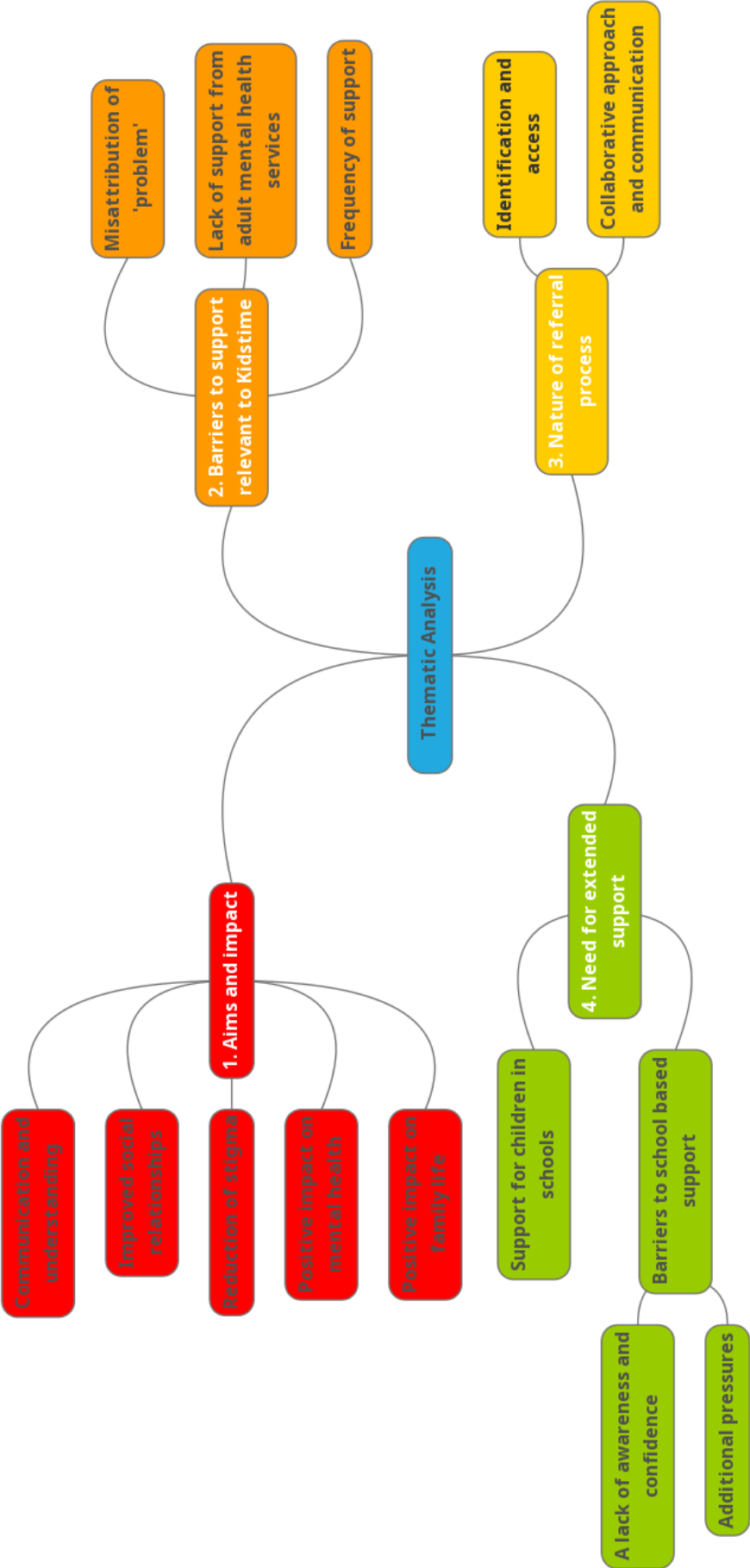
The following section presents the phase 1 findings. I have drawn together the data collected from Kidstime participants to generate four broad overarching themes. Themes and subthemes within this section are described, alongside comments illustrating these. Some comments have been shortened, or adapted for clarity, whilst the meaning has been maintained. Appendix L provides details of the individual group themes that contributed to each overarching theme. As qualitative research samples are not designed to have numerical or statistical inferences made from them (Ritchie et al., 2014), I have not indicated how many comments contributed to a particular theme. I have however made reference to the times in which all participants made reference to the same theme, to indicate the salience of that theme. This decision was made to ensure

that the presentation of the research findings remain in line with the purposes of qualitative research (Ritchie et al., 2014).

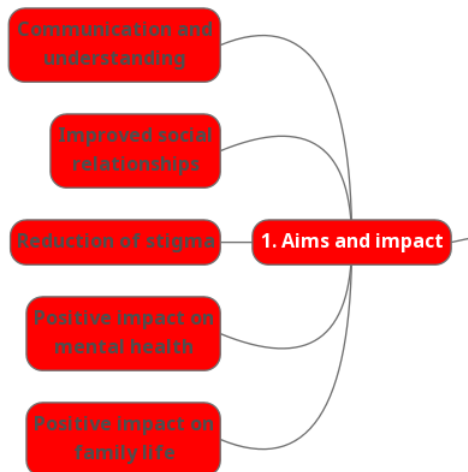
Figure 2 over the page presents the overarching themes and subthemes in a thematic map.

Figure 2:

Thematic map representing the global themes and subthemes for the phase 1 data.



4.3.1 Aims and Impact



4.3.1.1 Communication and Understanding

Communication and understanding were two dominant categories relating to the aims and impact of the Kidstime intervention, based on the content of interviewees' comments. Kidstime facilitators suggested that the aims of the Kidstime workshops focused on promoting communication about mental illness within and between families, in order to enhance understanding.

"Kidstime is ultimately about communication and understanding. It's about the parents understanding the impact of their mental illness on the children and finding the language to communicate it" (Anna, facilitator)

Kidstime facilitators recognised changes in a child's behaviour that they felt were reflective of feeling more able to communicate their thoughts and feelings.

"I've seen huge changes in children's confidence and their trust for us as adults, in the way they talk to us and open up" (Matthew, facilitator).

The children interviewed often had their own way of explaining mental illness, making reference to their own situation. Even one younger child (Lucy, age 6) was able to express her understanding of mental illness in relation to her own experiences. In the comment below, Lucy is referring to a time when her mother was admitted to hospital due to mental illness.

"Sore heads are like things where you need to go in to hospital and fix that bit and then that's when we started doing Kidstime. What it means is that your brain is not doing anything right" (Lucy, child).

In discussion with the children about some of the art work that they had created, I was able to gain an insight in to how the creative activities provided at Kidstime allowed children to express themselves in relation to their own situation. Referring to her art work, Penny (child) commented:

“It’s emotions. There’s a brain in the middle and all the emotions going around. It’s our body and brains ...Mummy’s brain. Sometimes she’s happy, sometimes when I come home from school she’s crying on the sofa”.

Some of the parents also commented positively on the opportunity to engage in more creative activities themselves, allowing them to express their own thoughts and feelings.

“Where we have been doing poems... I have been finding it an easy way to express how I feel... Normally I can’t explain how I feel to anybody...my whole head goes blank” (Emily, parent).

Comments made by the parents at Kidstime also reflect that opening lines of communication around mental illness within sessions, facilitates ongoing communication within families outside of Kidstime workshops.

“I said this is what bipolar is like... but it doesn’t last forever, maybe next month I might be lying on the settee with my eyes closed, crying my eyes out and not playing with you. And I said, ‘Now do you understand?’, and she said ‘yes, I know what bipolar is now’” (Zara, parent).

The provision of appropriate language and avenues for creative expression appear to be associated with an increase in the adult’s understanding of the impact of their illness on their children, based on improved communication.

“I’ve been really encouraged by the way that creativity has allowed them to express things that possibly they wouldn’t have expressed before coming to Kidstime. ...The adults begin to see how the children are using creative activities to explore some of these issues and the influence of illness on them” (Matthew, facilitator).

“...I wasn’t aware how much [my mental illness] affected [the children]. Through Kidstime I’ve been able to see things in their eyes and how they perceive them...I didn’t realise they understood as much as they did”. (Emily, parent).

When thinking about how things had changed as a result of Kidstime, some of the children made comments that reflect an increased understanding of mental illness and their own circumstances.

“For me, I’ve got more information about mental illness and what it is about. I can help mum more now because I understand” (Ella, child).

“By talking about it, it exposes [mum’s] feelings” (Penny, child).

4.3.1.2 Improved social relationships

Interviewees comments reflect a positive impact on social relationships and feelings of reduced social isolation.

“For all the families, it’s about connecting with other families and feeling they are not alone. I think there is something about universality, what groups can do is sort of remove some of that isolation and perhaps stigma...” (Anna, facilitator).

The majority of children interviewed made reference to having fun and spending time with friends, highlighting an impact on social relationships. Children made reference to Kidstime as an opportunity to spend time with friends, away from the norms of everyday life.

“It’s fun and we do more stuff, we don’t just have to sit at home, bored... [I like] having more fun and making new friends” (Penny, child).

Parents and facilitators made reference to the individual children’s group at Kidstime providing children with the ‘chance to be children’.

“They like to come for the social side... it gives them a chance to be children, time where they don’t have to worry about their parents for that hour” (Olivia, facilitator).

All parents interviewed suggested that spending time with others in a similar situation was valuable; providing them with a chance to discuss their difficulties without fear of judgement and share ideas about ways forward.

“I’m with other people that are like me, I don’t have to put on a face, like you do 24 hours a day. You can be yourself” (Zara, parent).

“For support. And to be with people that actually understand how I feel” (Becky, parent).

“I’m able to talk about different things that people have got similar sort of experiences... sharing what things we did to help us cope and strategies” (Kate, parent).

Some comments reflect the atmosphere of Kidstime as akin to a family gathering, supporting families to feel less isolated and promoting a sense of belonging.

“[Mum] really likes Kidstime because it’s supportive and a bit like a family” (Ella, child).

“It’s a combination of an educational event and a family party” (Matthew, facilitator).

“... giving them somewhere to belong and ensuring the big Kidstime family bit is vital” (Sam, facilitator).

4.3.1.3 Addressing stigma

A number of interviewees referred to stigma surrounding mental illness, with this being reduced in Kidstime sessions. When discussing her improved confidence to talk about her mental health difficulties, parent Zara commented:

“[It’s] because I know I’m not being judged as a silly, mental, idiot. These people are like me”.

Others’ comments reflect that Kidstime has helped some parents to be less judgemental of their own and others’ difficult situations.

“I was really ashamed of my mental health, before I came to Kidstime, but then I realised like it doesn’t define you... it’s just a thing that’s happened in your life” (Mollie, parent).

All facilitators emphasised the importance of modelling the language and behaviour that Kidstime advocates; to provide the language to talk about mental illness and begin to address some of the stigma that surrounds it.

“It’s the vocabulary that we use. We actually say illness and not use other abstract words for it” (Maggie, facilitator).

“We are quite direct with our use of language... naming it and talking about it openly, which is then part of that de-stigmatising really” (Sam, facilitator).

Comments made by some of the children suggest that stigma around mental illness is still experienced in their everyday lives.

“... I don’t like talking about my mental health because my school have a lot of bullies, and if you have something wrong with you, they think it’s okay to take the mick” (Ella, child).

4.3.1.4 Impact on own mental health (parents and children)

A number of parents and their children made reference to an improvement in their own mental health and attributed this to Kidstime attendance.

“I think I am happier in myself, I’m not so snappy. I can understand myself and I’m not so hard on myself” (Mollie, parent).

Other parents noticed improvements in their child’s mental health and resilience. When discussing changes in her child as a result of Kidstime attendance, (parent) commented:

“She’s got more confidence she’ll tackle things, instead of just leaving it”.

Some children reflected that their own mental health had improved as a result of attending Kidstime.

“I like coming here because it helps me stop worrying about things. ... I can stop hiding from things” (Ella, child).

“...[Kidstime] helps me with my anger because it helps me calm down” (Zac, child).

4.3.1.5 Impact on family life

Another area in which an impact of Kidstime was recognised was family relationships and functioning. Participants made reference to the idea that Kidstime attendance was associated with more positive experiences within the family.

“I’ve been playing with Alice more and she’s been giving me hugs and kisses and saying: “I love you mummy”. Whereas none of that would have happened before Kidstime... we just didn’t get on and I was upset. But now we’ve got a bond, and we’re happy, it’s so much better. It’s changed my life really” (Zara, parent).

“My relationship with Blake has improved, we’ve got a lot closer” (Becky, parent).

When questioned about what parents felt had supported the relationship, parents often commented on a better understanding of each other (parent and child), and improved communication.

“Seeing the way Tom sees [mental illness] as well seems to have helped” (Mark, parent).

“They’ve got a better understanding... I will tell them I don’t feel right and I feel sad and I’ll get lots of extra hugs” (Emily, parent).

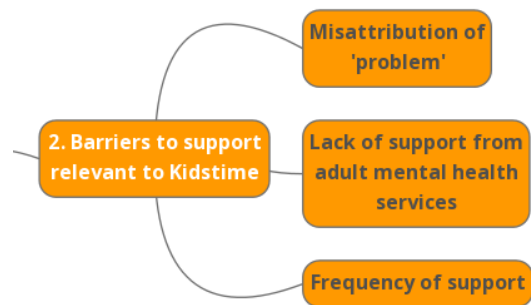
Some parents commented on changes to their own responses to their children.

“...before I might have shouted at her, but now I’m calmer” (Zara, parent).

“I think it’s also taught me not to be so aggressive when I’m sad ... I’m a lot calmer” (Emily, parent).

When drawing her favourite part of Kidstime, Lucy (aged 6) chose to draw a ‘family’ of shapes. When questioned about her drawing Lucy said: “The kids are at the top and the parents are at the bottom”, possibly representing her understanding of the hierarchy of Kidstime with the children’s needs highlighted as predominant. Lucy chose to draw all of the shapes smiling and explained “it’s because they like being happy”. This could be interpreted to suggest that Lucy’s understanding of Kidstime is that it is based on family units, and promotes positive feelings, although she did not, and possibly could not, verbalise it in this way.

4.3.2 Barriers to support relevant to Kidstime



4.3.2.1 Misattribution of ‘problem’

It is important to note that although some parents did appear to recognise the link between their own mental illness and their child’s needs, some did not reflect that they understood the mechanisms by which intergenerational mental health needs may come about. The narratives of some parents placed the ‘problems’, as being ‘within-child’.

“They’ve linked Blake’s anxiety with my mental health problems. So, they want me to do something about mine to see if it would help improve Blake’s. [Support worker] is the one that blames the way that Blake is on me” (Becky, parent).

Becky (above) is a parent who was referred to Kidstime as part of a social care support plan. Becky reported that she struggled to accept this initially. When discussing the above comment further with Becky, it became evident that she felt she had since proved these professionals wrong, because even though her mental health has now improved, her child still experiences difficulties.

Some of the children themselves also reflect the narrative that Kidstime is about addressing their own mental health needs and behaviour. Zac (child) commented: “[Kidstime] helps me with my anger because it helps me calm down.

Facilitators commented on the difficulties with misattribution of ‘problem’ as one of the biggest barriers to progress in Kidstime sessions.

“We see through Kidstime, children often get scapegoated with the difficulties because they are largely powerless in the system, so by helping the parents to come to terms with and explore some of the difficulties, and allowing them to talk about them, hopefully we begin to start to create a more holistic understanding of where some of these difficulties arise, rather than be placed with the kids” (Sam, facilitator).

4.3.2.2 Lack of involvement with adult mental health support services

Interviewees suggested that the nature of the parent’s mental illness itself can be a barrier to their engagement in the sessions. Some of those interviewed suggested that adult mental health support for the parents in attendance was lacking. Although Kidstime does not claim to be a mental illness support group or treatment intervention, there nevertheless appears to be unmet needs among the parents in attendance, that may have an impact on their children. Some of the comments made by parents highlight the significant difficulties they continue to experience on a daily basis.

“I have to have 3 hours sleep during the middle of the day because I find the day is too long and I get really depressed and low, so I have to have a sleep because I can’t get through otherwise” (Zara, parent).

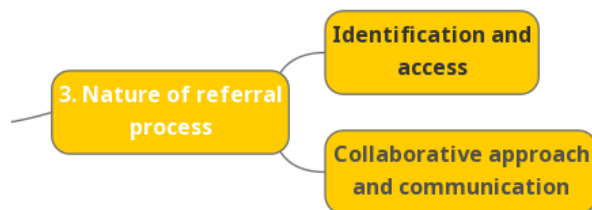
One parent made contact with me a couple of days after the interview to ask about any additional support for her mental illness, explaining that she felt she needed more support than she was being offered from health-based services, highlighting an 8 week wait between appointments. After permission to liaise with the Kidstime team regarding this, the parent was signposted to some additional support services.

4.3.2.3 Lack of consistency/frequency of support

Facilitators, parents and children all commented on the frequency/duration of the Kidstime intervention, expressing that more regular support would be beneficial. Some facilitators felt it could potentially be difficult to maintain progress if attendees did not have access to support between Kidstime sessions.

“Just because [something] has been acknowledged a couple of sessions ago, it doesn’t mean that that acknowledgement is always going to stay at the forefront of awareness and thinking, so, coming back to that, and continually being able to pick up a thread, I think is really important. ...Once every two weeks... is that enough to maintain that thread? I don’t know. Certainly, it’s going to be a challenge if you’re not surrounded by other people that support that reflection, and that would be a concern of mine” (Sam, facilitator).

4.3.3 Nature of referral process



4.3.3.1 Identification and access

A number of parents and facilitators commented on the ease of identification and access to Kidstime, making reference to the school-linked referral process.

“The schools are right there and [the referral] comes through the multi-agency team and it’s quite sleek and it’s quite a clear footpath” (Maggie, facilitator).

Facilitators made comments about the fact that referrals for support were considered at a professional’s panel meeting, consisting of predominantly educational psychologists and therapists. Comments made reflect the notion that sometimes schools have not necessarily identified the need for an intervention such as Kidstime, rather they request individual support for the

child who may be demonstrating concerning behaviour. However, it was noted that the professionals at the panel quite often make links with family situations and highlight the need for more holistic support.

“The team can see the threads in the referral and decide what’s best” (Maggie, facilitator).

“For me it makes perfect sense for Kidstime to be linked to the multi-agency team, so that there is all that other professional expertise that surrounds it too” (Matthew, facilitator).

Parents made reference to their child’s school as having successfully identified that the family was in need of support. Some highlighted the increased focus in schools to support the emotional needs of children.

“I think [the school] knew I needed some support, I had just left my job through mental illness... In school, they knew something was going on with me” (Kate, parent).

“School these days isn’t just about turning up... they concentrate a lot more on the emotional needs of each child and recognising that every child is actually individual and I do think they make an extra effort to support each individual child...” (Emily, parent).

When speaking with participants about health-based referral systems for Kidstime that operate elsewhere, there were mixed thoughts about this. All felt that the school-linked model was preferable to a solely health-based system. Comments made reflect the feeling that school staff are better positioned to identify those in need and would be more likely to be able to offer quick and effective support suited to the families’ needs.

“It’s better from school because they are around children so they can pick up things quicker” (Zara, parent).

“I think the teachers get to know the children better. So, whereas you get a five-minute consultation with a doctor that doesn’t know the children... you get a better understanding of what the actual issues are with the children” (Emily, parent).

When considering an alternative, health-based referral system, Maggie (facilitator) commented:

“I think we would lose that connection with schools and the network...”

Some parents and facilitators identified potential advantages of health-based referrals. Some interviewees suggested that closer links between education and health services would further increase the availability of interventions such as Kidstime, highlighting the benefits of collaboration. Facilitator Sam felt partnership working would be preferable, with adult mental health leading the intervention and holding the budget. He highlighted that such interventions might reduce the strain on adult mental health services. Parent Mollie felt that Kidstime in Southbridge is not accessible for some families as it only targets school-aged children.

Participants commented that solely health-based referral routes are likely to miss children whereby their parents aren't known to adult mental health services, or where the child's difficulties do not reach the threshold for mental health support. This is the case for a number of families attending Kidstime in Southbridge.

“We should have a link [with adult mental health]. A lot of the [attendees] don't have any community psychiatric services at all, no CPN or anything... it would be useful, sometimes, to have that link in I think” (Maggie, facilitator).

Both facilitators and parents did however have reservations about the availability of mental health support services, and the way in which those in need would be identified. Some parents also remarked that they struggle to access health services due to their needs.

“I think it's good to have it in schools... you aren't always going to want to go and see a doctor and half the time you can't even get in to see a doctor...I find it really difficult to go and see a doctor” (Kate, parent).

“Mental health services that they have access to are either not available, or they are on a waiting list ...School see those children every day and they know the impact that it has on those children... schools are pretty good at noticing those signs for those families...” (Olivia, facilitator).

4.3.3.2 Communication and collaboration

Parents and facilitators made reference to the benefits of having a network of joined-up professionals involved in supporting the family. Some families noted specific examples of where they had received additional support from school staff and the multi-agency team, as a result of effective communication and collaboration between Kidstime and school staff.

“[there is] communication with schools, learning mentors or keyworkers, so that network and link is there” (Maggie, facilitator).

When referring to family support worker from multi-agency team, Kate (parent) commented: “It just helped me having someone to walk through the door with who I knew”.

Comments made by interviewees reflect the idea that school settings provide opportunities for frequent and positive communication with school-based staff who may be able to provide support for parents and their children. A number of parents and facilitators commented on the crucial role of parent support advisers in identifying vulnerable families, building relationships and providing and signposting support.

“PSAs are so much on the ground, they can become so close to those families, they are picking up on things that would be missed otherwise” (Matthew, facilitator).

When discussing the parent liaison at her child’s school, Emily (parent) commented: “We built up a relationship, she knew I had lost my mental health social worker and she kind of took on that role even though it wasn’t her job and she still does to this day”.

4.3.4 Need for extended support



4.3.4.1 Support for children in schools

A number of interviewees made reference to schools being well positioned to meet the needs of vulnerable children and families, yet they could identify little support available at present. Some parents expressed the importance of raising the profile of mental health issues in schools and felt that teaching about mental health and illness in schools would allow a larger group to experience the benefits, building a network of understanding and support.

“Kidstime has taught me that [talking about mental illness] doesn’t have to be bad. [Children] need to learn about it because it is happening everywhere in the world it’s a subject they need to learn about” (Mollie, parent).

“If you are doing it in a school, you’ve got more children in that area understanding health issues ... you’ve got a whole class that can benefit from it” (Mark, parent).

Others’ comments further reflect the suggestion that COPMHN need a support network around them in school, with opportunities to spend time with peers who can relate to their experiences.

“It’s difficult because her friends don’t understand the lifestyle she has. You know they can do anything; she has to work round us” (Zara, parent).

When asked about whether it would be helpful for school staff to know about Kidstime, Zac (child) said: “Yeah. Because then they would know what I would be doing here, so I can do it in school as well”. This comment suggests that Zac values the support of Kidstime and might benefit from aspects of the support he receives there within the school environment.

4.3.4.2 Barriers to support in schools

4.3.4.2a A lack of awareness and confidence

The majority of interviewees talked about the difficulty identifying vulnerable families and children. Firstly, they felt that school staff were not necessarily trained to look for the signs that a child might be living with a mentally ill parent, and secondly, they acknowledged that parents are unlikely to be forthcoming in

identifying their difficulties, through fear of being judged.

“There’s still a lot of stigma about... am I a good enough parent? And what people are thinking of you and thinking because you have a diagnosis of something that you won’t be able to cope. I think there is still a lot of fear” (Maggie, facilitator).

When speaking with one parent (Zara) about her communication with her child’s school she said: “I don’t go down there [because of] self-image, paranoia, making conversation”.

Interviewees discussed the fact that sometimes the child will be identified as having concerning behaviour in school, but this is not always considered in relation to their family situation.

“To me there is no joined up thinking between the 6 hours your child is in school” (Mollie, parent).

Comments made by interviewees suggest that teachers and support staff do not always feel confident to deal with issues around mental illness. The Kidstime facilitator who was also a parent support adviser, mentioned that in her role as a PSA, she was expected to deal with the ‘taboo’ subjects, as other members of the school staff felt uncomfortable and unskilled to deal with such matters.

“I think it’s the understanding of [mental illness]. I think [school staff] are quite fearful of it themselves so, anything to do with mental health they say ‘oh can you deal with that?’” (Maggie, facilitator).

When asked whether or not he felt schools were aware of the needs of COPMI and how they might be supported, Matthew (facilitator) responded: “No I don’t. I think there is a huge gap. I think school-based professionals like myself are only just beginning to talk about mental health generally”.

4.6.4.2b Additional pressures

Some interviewees discussed the pressures that school staff may feel in regard to academic standards and progress, highlighting this as a barrier to other types of support.

“There has always been an inclusion versus standards issue, we’re sadly, more in the camp of standards, with the pressure and the

judgement and measurement being progress and grades, less concern with the value-added stuff” (Sam, facilitator)

“I think it’s school staff not having the time because of the pressures from Ofsted and the curriculum” (Olivia, facilitator).

Facilitator’s comments highlighted capacity and resourcing issues as barriers to effective support being put in place in schools. It was noted that teachers have a lot of additional responsibilities, with a lack of training to fulfil some of these.

“There is a lot expected of schools ... there are various needs, they don’t have the training to meet a lot of the needs that they are expected to meet” (Sam, facilitator).

4.4 Phase 1 Discussion

I will now discuss the global themes and subthemes in relation to the original three research questions presented for phase one.

4.4.1 Aims and impact of Kidstime

Based on the findings, I feel the fulfilment of the Kidstime aims is best understood in relation to the perceived impact, therefore research questions 1 and 2 will be answered alongside one another. In order to make clear how the experiences of Kidstime participants align with with the stated aims and objectives of Kidstime, relevant information from the Our Time Foundation website is included below.

The Our Time Foundation (2019) states the aims of Kidstime workshops to be:

“‘non-treatment’ educational sessions which encourage families to discuss mental illness and help to diminish the social isolation, stigma, confusion and fears which a child of a parent with mental illness may experience”.

The Our Time Foundation (2019) states that:

“The workshops offer a fun, protected space where young people can express themselves, interact socially, share experiences and learn about mental illness through discussion, games and drama. Trained staff explain mental illness and its effects to young people in a way they can understand and help them to articulate and tackle concerns or challenges. The workshops also provide adults with an informal, intimate space, where they have the opportunity to share experiences and discuss their role as parents rather than patients.”

Based on the findings from this research, it appears that the aims of Kidstime as outlined by the Our Time Foundation (2019) are realised based on the impact of the Kidstime workshops in Southbridge. Themes drawn from all groups (parents, children and facilitators) suggest impacts in the following areas: improved communication and understanding in relation to mental illness, improved social relationships and reduced isolation, reduced stigma, a positive impact on own mental health (parents and children) and a positive impact on family relationships. Barriers to support and the potential impact of these were also recognised among Kidstime attendees and facilitators, specifically in relation to the misattribution of the 'problem', as being 'within-child', rather than based their situation, and a lack of collaboration with adult mental health services.

Comments made by Kidstime attendees and facilitators reflect the idea that the aims of increasing communication and understanding regarding mental illness are achieved in the Southbridge workshops. Grove, Reupert and Maybery (2013) suggest that providing children with accurate, age-appropriate information about mental illness can address misconceptions and fears, improving understanding. The authors also emphasise the importance of using the correct language to be able to talk about mental illness, which is something acknowledged by the participants in the current research.

Increased understanding and expression relating to mental illness has been linked with an increase in children's resilience, empathy for their parent and improved communication between parent and child (Grove et al., 2013; Wolpert et al., 2015). The expression 'knowledge is power', conceptualises the ability to improve one's circumstances as a result of increased education and knowledge about a personally relevant topic (Reupert & Maybery, 2009). Knowledge relating to a parent's mental illness is said to provide 'power' to the children in these families and may reduce the likelihood of future mental health needs of their own (Reupert & Maybery, 2009). Experimental studies add weight to this idea, suggesting that interventions promoting open communication between parents and children where the parent has a mental illness can enhance the child's understanding of their parent's difficulties and reduce their intergenerational risk of mental illness (Beardslee, Wright, Gladstone & Forbes, 2007).

Opportunities for the creative expression and communication of thoughts and feelings are recognised as central to the Kidstime approach (Our Time Foundation, 2019). Such opportunities appear to be valued and considered effective by the facilitators and participants in this research. The current research highlights that drawing and other creative activities can provide an opportunity for children to express themselves in a different way, when they perhaps struggle to verbalise their thoughts, feelings and understanding. This corroborates findings from previous research suggesting that creative activities can give meaning and aid in understanding in relation to puzzling and scary experiences that children encounter in their lives (Clements, Benasutti & Henry, 2001; Engel, 1995).

The Our Time Foundation (2019) states that Kidstime workshops provide social opportunities which can potentially reduce feelings of social isolation. Social isolation can result from the symptoms of mental illness and may also be a consequence of the associated stigma, disadvantage and social exclusion that those with mental health needs may face (Harvey & Brophy, 2011). Children of parents with mental illness can often find it difficult to make and keep friends (Cogan, Riddell & Mayes, 2005; Hall, 1996), and can grow up to become adults who struggle to connect with others (Foster, 2010).

Both adults and children interviewed for the current research were able to recognise the impact of Kidstime on social opportunities and relationships, with comments reflecting reduced experiences of isolation and the promotion of a network of support. The findings from this research are reflective of Bilsborough's (2004) research, which highlights the value of children learning that they are not the only one experiencing parental mental illness, based on their contact and socialisation with others in a similar position.

A sense of belonging is recognised as important in relation to mental health (Hagerty, Lynch-Sauer, Patusky, Bouwsema, & Collier, 1992). This is something that emerged in the current research, with some interviewees referring to the Kidstime group as a 'family' that provide understanding and support. In relation to the hierarchy of human needs, Maslow (1943; 1954) identified belonging as a basic human need, ranking it as third most important. It has been posited that belonging is the missing conceptual link in understanding the relationship and interaction difficulties for those experiencing

mental illness (Anant, 1966). It has been suggested that individuals' perceptions of their interactions and relationships may be far more powerful determinants of mental health disorders than previously thought (Antonucci & Israel, 1986). Interventions such as Kidstime appear to have the potential to heighten one's sense of belonging and connectedness with others in a similar position, through the social opportunities it provides. This could potentially contribute to more positive mental health in the long-term for those that attend interventions such as Kidstime.

The Our Time Foundation (2019) highlight an aim of the workshops as reducing stigma in relation to mental illness. A number of interviewees referred to stigma surrounding mental illness, with this being reduced in Kidstime sessions. Parents often reported improved confidence to talk about their mental health difficulties and attributed this to improved social relationships and not feeling judged by others. This finding is reflective of research by Weist et al., (2002), which suggest that school-based family support interventions can reduce feelings of stigma.

As discussed, comments made in this research highlight that Kidstime provides opportunities for honest and open conversations about mental illness, using direct language. Previous research suggests that such open and explicit discussion has a positive impact on increasing communication and self-expression, which can reduce stigma and increase resilience (Grove et al., 2013; Wolpert et al., 2015). Those interviewed reflected that people are not used to talking so openly and frankly about mental illness, as this is not the norm. Despite feeling a reduction in stigma during the Kidstime sessions, a number of those interviewed made reference to the ongoing stigma in relation to mental illness that they experience outside of Kidstime. In relation to this, some commented that this would prevent them wanting to seek support outside of Kidstime. It is therefore important to consider the wider societal issues that may impact these families in their everyday lives.

Research suggests that stigma tends to be fuelled by misunderstandings of the causes of mental illness, stereotypic beliefs, and lack of government funding given to support integrated mental health systems (Stuart, 2016). Findings from the current research reflect these misunderstandings. This links back to the

theme of communication and understanding highlighted in the current research and reinforces the need for increased communication and teaching outside of specific intervention contexts, in order to address a lack of understanding and associated stigma in wider society.

Although Kidstime does not claim to be a mental health intervention, some of the families recognised a positive impact on aspects of their own mental health as a result of attendance. It may be that in addressing other areas (communication and understanding and social and family relationships), parents' situations became more positive, promoting more positive mental health. Some parents attributed this positive impact on their mental health to an increased self-awareness, understanding and acceptance. It was noted by some, that opportunities for creative expression allowed them to better understand their own thoughts and feelings relevant to their difficulties and situation. It follows that this may support individuals to better understand how to help themselves and other family members in relation to these difficulties.

Some children also made reference to their own mental health needs. The notion of escapism was reflected in some of the children's comments, where they positively discussed being away from the family home and 'having more fun'. Cooklin (2013) highlights the importance of children being provided with opportunities to achieve distance from their parent's emotions and behaviour, in order to better identify and understand their own emotions and experiences. This research highlights the value placed on opportunities to escape the realities of everyday life, and the chance to focus on age-appropriate activities. Cooklin (2013) suggests that opportunities for fun and age-appropriate activities rebalance the child's 'inverted' role as a young carer within the family, which can have a positive effect on mental health.

Research has suggested potential difficulties in parent-child relationships where the parent has a mental illness (Nilsson, Gustafsson & Nolbris, 2015; Petrowski & Stein, 2016). Comments made in the current research suggest that the improvement in family relationships was a reflection of the other positive impacts experienced: communication and understanding, improved social relationships, improvements in own mental health (parent and child) and reduction of stigma. Through learning to communicate more effectively with one

another, and having an understanding of each other's perspectives, it may be that both parents and children are more attuned to one another.

Previous research states that relationship formation and attachment patterns are pathways affected by parental mental health (Apter et al., 2017). Perhaps Kidstime offers time and space, with support from professionals for parents to become more attuned to their children, and vice versa, promoting an overall more positive relationship. Parents interviewed in this research commented that aspects of their parenting style had changed, suggesting that they are relating to their children in a more positive way than before. Comments made reflect that as a result of a better understanding of the impact of their mental illness on their children, some parents have adapted their response to their children, from one of aggression and anger to one that is calmer and more controlled.

Research suggests that excessive, prolonged, and inappropriate anger directed at a child can result in problems of attachment (Brockington et al., 2013).

Therefore, if parents are now able to change their behaviour, and respond in a more positive way, it follows that their relationships can also become positive.

Research suggests that when parent-child relationships are improved, the child's resilience to future mental health problems is enhanced (Rutter, 2003; Tienari et al., 2004, 2006).

If relationships can be supported appropriately by interventions such as Kidstime, the intergenerational persistence of mental illness could begin to be addressed, in a preventative way, as opposed to the more reactive way that mental health needs are currently approached (BPS, 2018b). Kidstime however is not an intensive intervention, and therefore other support is likely to be needed to support children and families in their wider context in order to make a significant difference.

In relation to the aims and impact of Kidstime, a number of barriers to the fulfilment of these were noted by those interviewed. One barrier was that some parents do not acknowledge how the needs of their children may be related to the parent's mental illness and associated behaviours. To my knowledge, this finding has not been noted explicitly in other literature. A number of parents discussed the difficult behaviours displayed by their children, with this being a dominant narrative for some parents. Facilitator's discussed that sometimes children's needs can take up so much of the parents focus and attention, they

can fail to recognise how their own behaviour as parents may, in part, contribute to or perpetuate their children's difficulties. Facilitators in the current research recognised that this can affect progress for the family. The concern around this is that children may begin to internalise their parent's narrative, that the children themselves have a 'problem'. At the same time, parents are not in a position to reflect on their own needs and behaviour, as they focus too heavily on the child's behavioural presentation. If a 'within child' narrative continues, the child may not achieve the understanding that they have the ability to change and be resilient in relation to their situation, as they are bound by their internal 'problem'. These children may also end up being assessed for various needs without acknowledgement of their position as a COPMHN (The National Society for the Prevention of Cruelty to Children (NSPCC) 2015). Some of those interviewed made reference to this unintentional 'scapegoating' as being a societal issue, with children being "largely powerless in the system". O'Hare (2017) highlights that initiatives such as the mental health first aid programme previously discussed, perpetuates a within-child narrative about mental ill health, targeting 'treatment' at the children, rather than recognising the wider systems in which they are involved, further reinforcing the misattribution of the 'problem'.

Another barrier to support highlighted by the current research was a lack of involvement with adult mental health support services. Previous research notes that such services often struggle to consider the familial impact of a client's mental illness (Ofsted, 2013). Family and relationship focused interventions for parental mental illness have demonstrated the potential to reduce the future costs to healthcare systems, yet such preventative interventions are often charity funded (Reupert & Maybery, 2011) or, as in Southbridge, funded via independent services requiring schools to pay. A number of those interviewed made reference to the lack of involvement from mental health support services, despite highlighting the potential advantages of this. Those interviewed did however acknowledge the strain on mental health support services due to a lack of resources.

Some of the participants interviewed commented on the fact that Kidstime is not as frequent as they would like, highlighting a need for further support. All facilitators interviewed highlighted the long-term need for the intervention,

emphasising that the impact can take a while to be seen, and may never be recognised explicitly. Facilitators highlighted that progress is not always linear and can show regression, often due to the unstable nature of the lives that families experiencing mental illness may live. This further emphasises the need for longer-term support that can be consistently available.

4.4.2 Experience of the process and context of the school-linked referrals.

This section focuses on research question 3: How do participants and facilitators of Kidstime experience the process and context of the school-linked referrals? The referral context in Southbridge is school-linked, as opposed to a health-linked referral system operating in all other Kidstime workshops. Based on the responses of those interviewed, the school-linked system was positively received, with participants making reference to effective identification of those in need and easy access to support, as well as positive communication and collaboration between school staff and the multi-agency team that facilitate Kidstime. Those interviewed identified a need for extended support in schools, but also highlighted potential barriers to such support being put in place.

Those interviewed generally felt that a school-linked referral context for Kidstime was appropriate and was most likely to reach families in need in comparison to other health-based referral contexts. This is reflected in previous research highlighting identification and access opportunities that schools can provide (Kern et al., 2017; Weist et al., 2002). The multi-professional team in Southbridge was deemed to be effective in triaging referrals and allocating appropriate support to families who need it, by exploring the systems in which a child is involved, rather than just focusing on the child themselves. This highlights the benefits of professionals such as educational psychologists, who form part of the panel in Southbridge. Educational psychologists are in a unique position to have a ‘helicopter’ perspective on a situation (Wagner, 2000), making links between circumstances and behaviours in order to advise on appropriate support.

Interviewees were often very positive about the communication and collaboration between Kidstime and school-based professionals in relation to holistic support for the family. As the Kidstime facilitators are also employees of

the multi-agency team, they are able to be flexible in their support for the families attending Kidstime. This research highlighted the skills of the wider multi-agency team, which can be utilised to further support the wider needs of the children attending Kidstime. These professionals have the capacity to liaise with school staff and share relevant information regarding the Kidstime families in order to promote extended support between Kidstime sessions. This was valued by interviewees in the current research.

The role of the parent support adviser (PSA) or family liaison officer (FLO) was mentioned frequently, in relation to support for both children and families. PSAs are in a position to build positive relationships with parents over time and link in with other professionals as part of a multi-agency approach to supporting vulnerable children and families (Training and Development Agency for Schools, 2009). It is relevant to note however that this role is not fulfilled in all schools, despite its apparent value as highlighted in this research.

Although the school-linked referral model was highlighted as preferable, a number of interviewees did feel there were benefits of health-based models, in that they would allow access to support to a different population of those in need. Although health-based referrals would mean that some of the attendees currently at Kidstime would not have awareness or access, a joint approach between education and health could be beneficial in increasing identification and access to such interventions. As discussed in the literature review, a joint education and health care approach where adult and children's services can work collaboratively is considered to be the best way to safeguard children and to plan and deliver early intervention services (Rouf, 2014).

Those that attend Kidstime are arguably the people who are the most resilient of a vulnerable group, as often they have been able to overcome barriers to seek help for themselves or their children. It is therefore important to recognise the children whose parents are unable to access interventions such as Kidstime, or whose parents might not yet have been deemed appropriate to attend due to a lack of acceptance of their own needs and their possible impact. Participants in the current research also noted concerns around the frequency of the Kidstime intervention, highlighting a need for extended support between sessions.

As discussed, current mental health-based support interventions can be described as reactive, rather than preventative (CQC, 2017), which arguably have less chance of impacting the cycle of intergenerational mental illness. Intergenerational mental illness is not inevitable, and much can be done to mediate risk factors, recognise and build upon protective factors and strengthen the wellbeing and resilience of children and their families (Foster, O'Brien & Korhonen, 2012). This current research has recognised a number of ways in which psychoeducation and other forms of support can impact on wellbeing and resilience in families, and hence it may be beneficial to explore ways to implement such support at a preventative level in more accessible contexts, to increase support for children and families.

Research evidence suggests that school-based mental health services have the highest likelihood of reaching vulnerable children (Kern et al., 2017) and increase access for families (Weist et al., 2002). Durlak et al., (2011) suggest that the structured environment that schools provide allows for early identification, prevention and intervention in relation to mental health needs. Supporting vulnerable children in school settings means they can access early intervention before they meet the criteria for specialist mental health services (Barrett & Turner, 2001; Kern et al., 2017). Those in need are also most likely to make their needs known to school-based professionals in the first instance (Heads Together, 2018).

Despite the perception of interviewees that schools are well placed to support the needs of vulnerable children and families, there was little awareness of support available in schools currently. Some of those interviewed felt that raising the profile of mental health and illness in schools would benefit all children, giving them a better understanding of their own and other's situations. Others felt that teaching children about mental illness from a younger age was important. In educating children on the topic of mental illness, vulnerable children themselves may be able to identify as young carers, and access support available.

Significant barriers to school-based support were highlighted in the current research. Interviewees reported that school staff are not always trained or confident to approach parents in relation to topics such as mental illness and

therefore explicit conversations do not always happen. Interviewees discussed the fact that sometimes a child will be identified as having concerning behaviour in school, but this will not be linked to their family situation. As discussed, a lack of acknowledgement of a child's wider context can lead to individualised support being put in place (NSPCC, 2015), which is unlikely to be as effective as more holistic support (Acri & Hoagwood, 2014). It was also suggested that school staff are not necessarily trained to support the various needs that they are expected to. The guidance 'Mental Health and Behaviour in Schools' (DfE, 2018) suggests that school staff cannot act as mental health experts; however, it also states that they should recognise emerging issues as early and accurately as possible and support pupils to access evidence-based early support interventions. This research highlights the possibility that some school-based staff have not had the training to be able to fulfil some of these responsibilities.

The perception of a lack of awareness, knowledge and confidence amongst some school staff to deal with issues surrounding mental illness highlights a potential need for support and training in this area for these staff. It is important to consider however that this is a discussion of the perception of support available in schools, rather than a reflection of what is available. However, this perception mirrors findings from research previously discussed highlighting a lack of understanding, early identification and support mechanisms in schools (Bibou-Nakou, 2003; Bruland et al., 2017).

As discussed, this research has also highlighted the crucial role that parent support advisers (PSAs) can have in identifying and supporting vulnerable children and families, due to the positive, trusting relationship they can build, and the support they can provide to parents. However, funding cuts in education budgets (Belfield, Farquharson & Sibbels, 2018) mean a number of schools no longer have such a professional within their school (Unison, 2018), meaning that teachers and other school-based staff may be next in the line of communication and support.

Additional pressures have been highlighted by the current research that potentially impact on the ability of school staff to provide support to some of the vulnerable children in their care. Capacity and resourcing issues were

highlighted as barriers to effective support being put in place in schools, as well as the pressures of the national curriculum. Such pressures are widely noted in the literature as preventing schools from identifying and supporting the most vulnerable pupils (House of Commons Education Committee, 2018).

4.5 Phase 1 summary

The findings from phase 1 of my research suggest that the Kidstime intervention in Southbridge is successful in addressing the aims set out by the Our Time Foundation (2019). The intervention provides education to families regarding mental illness and its potential effects and provides families with the language needed to improve communication. The impacts of the intervention highlighted in this research include: increased understanding and communication, improved social connectedness and reduced isolation, an improvement in own mental health and an improvement in family relationships and functioning. These findings are reflective of Wolpert et al.'s (2015) findings with regard to the value of sharing time with those in a similar position, opportunities for learning and fun and recognising an impact on family relationships. The current research builds on these findings to recognise the components that contribute to a positive impact on families and clarifies the mechanisms by which Kidstime might impact on family relationships. This research also recognises the views of the facilitators of Kidstime in relation to their experiences and the barriers to progress that are observed. The current research also focuses on a school-linked referral model, rather than the traditional health service-linked system.

The themes and subthemes highlighted in this research can be seen to be interlinked. Kidstime is considered to support attendees in a number of ways, that lead to an improvement in overall wellbeing. This research suggests that increased communication and the ability to express oneself leads to increased understanding regarding parental mental illness. This can reduce feelings of stigma and increase a child's resilience (Grove et al, 2013; Wolpert et al., 2015) in relation to their parent's mental illness and own mental health. This improved communication and understanding can also promote more positive relationships within the family, as individual family members may become more 'attuned' with each other and have a better understanding of others' circumstances and perspective. The Kidstime intervention provides social opportunities both within

and between families, allowing them to discuss their difficulties in an open and honest way. This can lead to an increased sense of social connectedness and belonging, which may impact positively on mental health.

The school-linked referral context in Southbridge was positively received. Those interviewed made reference to increased opportunities for schools to identify potential families in need of Kidstime support, as they have increased access to children and families. Interviewees also made reference to the value of the communication and collaboration regarding support for families between the school-based professionals and Kidstime professionals.

Barriers to the successful fulfilment of the aims included; misattribution of problems as being 'within child', rather than a product of their situation, a lack of collaboration with mental health support services and concerns around the regularity of Kidstime workshops as too infrequent. Findings from this research also suggest a need for further support outside of the Kidstime context, most notably in schools, in order to increase the availability and continuity of support for these vulnerable families who may not have access to any other services.

4.6 Link to phase 2

Findings from phase 1 highlight the positive impact that a family-focused intervention such as Kidstime can have on children and their parents. Phase 1 did however reveal that further support for these families is needed, and that interventions such as Kidstime can only go so far in offering support for this vulnerable group. The Kidstime intervention itself, as well as the school-linked referral context in Southbridge was positively received. However, such interventions are not accessible for all families. The Southbridge Kidstime referral process itself deems that some families are not yet ready to engage in such an intervention. For phase 2a of my research, I therefore sought to explore the needs of COPMHN and their perception and experiences of school-based support. Phase 2b explored the awareness and understanding of school staff in relation to this vulnerable group, the availability of support and ideas for future support.

Chapter 5: Phase 2a

5.1 Phase 2a overview.

Phase 2a was an exploration of the views and experiences of COPMHN in relation to their needs and experiences of school-based support. In this phase I employed the use of focus groups, as summarised in chapter 3. Participants included four year 11 students and four year 8 students from one secondary school in Southbridge.

5.2 Research aims and questions

Research Question 4: How do COPMHN perceive their additional social, emotional and mental health needs?

Research Question 5: How do COPMHN perceive the support available to them in schools?

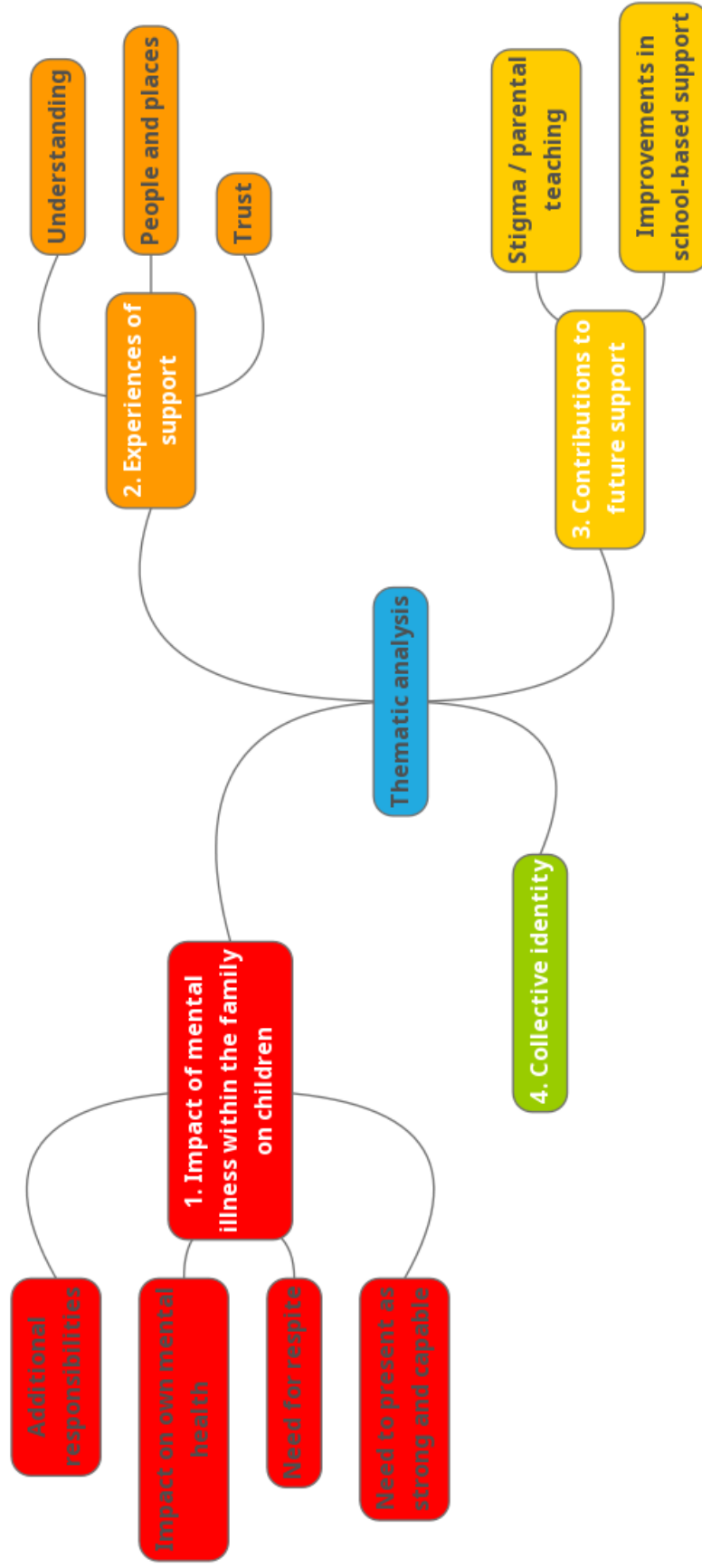
Research Question 6: What support do COPMHN of secondary age think could be implemented for their group in schools?

5.3 Phase 2a Findings

In this section, the findings from phase 2a will be presented. Global themes will be presented and discussed in relation to the subthemes that contribute to them. Figure 3 shows the global themes and subthemes derived from the phase 2a data.

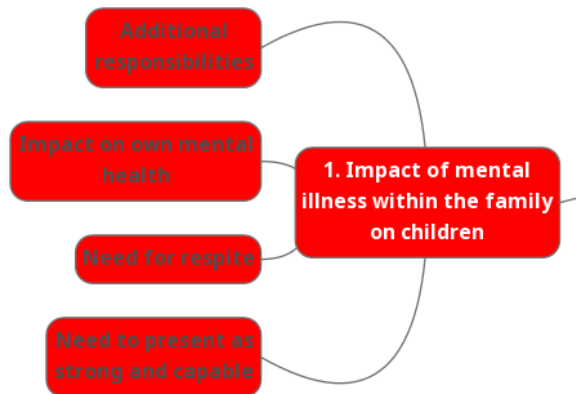
Figure 3:

Thematic map illustrating the global themes and subthemes for the phase 2a data



5.3.1 Impact of mental illness within the family

During the focus groups, children discussed the impact of familial mental illness. Despite being identified by school staff as having experienced parental mental illness, not all children chose to discuss this explicitly and hence the theme refers to impact of mental illness within the family.



5.3.1.1 Additional responsibilities

Students commented on a variety of responsibilities that cause them additional stress and sometimes interfere with school-based responsibilities and social needs. These included emotional and practical responsibilities. Children often referred to the more-adult like responsibilities that they must take on.

“You’ve got to grow up a lot quicker than you should have to... You’ve gotta go do shopping... you’ve gotta cook tea... you’ve got all the emotional strain on you, while you’re trying to study for exams, while your trying to have a normal life, trying to, like, socialise with your friends” (Annie).

“It’s the late nights, the early mornings, the emotional drainage, it’s not easy, especially because we are kids as well...” (Chloe).

Some students discussed the responsibility they feel for their parent and the impact that this has.

“How can I put myself first when I’m the only person in the house with my mum? She’s screaming in pain, she can’t do anything herself, trying to like overdose on her tablets...” (Annie).

5.3.1.2 Impact on own mental health

Some children referred to mental health needs of their own.

“I have... anger issues and stuff like that” (Daisy).

“What I don’t get about my anger issues is that I can control it in school but at home... I can’t control it” (Ashley).

One child commented that he felt his parent’s mental health needs were ‘passed on’ to him.

“It’s like, it gets passed on because you are depended on by someone with a mental illness and you have a lot of responsibility at home, and especially when you come to school, it’s a lot on your shoulder” (Brad).

Children discussed their thoughts and worries about the future, which they felt impacted on their ability to focus and engage in their learning.

“It kind of just stresses you because you’re having to learn, but you can’t think straight and then you get yourself in to a mindset that ‘right if I can’t learn this, what’s my GCSEs gonna be like? And over think it. Your head is in such a bad space...” (Chloe).

“I overthink everything all the time. I always think about when I move out how am I going to get money... if I don’t get a job because I don’t get my GCSEs...” (Darcy).

5.3.1.3 Need for respite

A number of the students spoke positively about spending time away from their responsibilities, highlighting a need for respite.

“When I’m out with my friends, I don’t care about anything, I just don’t care, I’m happy” (Daisy).

“They do a young carers festival where you can actually get away for the whole weekend... I think that it’s stripping us of that really big emotional weight” (Chloe).

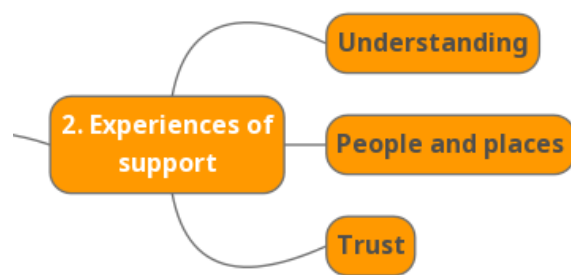
5.3.1.4 Need to present as strong and capable

A theme that emerged was a need to present as strong and capable. Children emphasised the importance of feeling or appearing in control.

“Bursting out crying is not a good thing for us, we wanna keep it in, we wanna keep controlled, for when we go home ...” (Annie).

“You wanna be a strong person don’t you? You don’t wanna show anyone you’re weak” (Darcy).

5.3.2 Experiences of support



5.3.2.1 Understanding

A number of children commented on experiencing a lack of understanding from some of the adults supporting them. Some children felt that academic achievement was considered above and beyond emotional wellbeing. Some children felt that some school staff had not been considerate of the child’s circumstances.

“If you didn’t do well, you pretty much got kicked off the course, it was your fault you didn’t do well, nothing to do with anything that was going on at home... they shout at you no matter what, make you cry and then be like ‘sorry about that, we do know what’s going on’, sorry no... no you don’t!’ you wouldn’t do that in the first place if you did know what was going on” (Annie).

Some children commented on a lack of understanding from their own friends and highlighted that they felt their difficulties had been minimised.

“I said to someone who is like my closest friend, [I live] at home with someone who is suffering depression and she went ‘oh yeah I know about that’ and I just thought, well you don’t really know because I haven’t told you ... she said ‘oh don’t tell me anymore, I don’t care’, it just felt really upsetting...” (Cassie).

Many of the children commented on feelings of isolation and on the importance of having a connection with someone who understands them and has been through a similar experience.

“It’s like, imagine a snail shell, really random, but it’s like, you’re in there and there is no one else technically in the same boat that you can relate to and even if there is they are really, really hard to find” (Daisy).

“If I was having a really low day, and I wanted to speak to someone it would help me a lot knowing that I could come to one of you guys” (Chloe).

5.3.2.2 People and places

In relation to positive experiences, children referred to places they can go if they are experiencing difficulty and people that they could access for support.

“You can have time to relax, and if you are feeling under pressure you can stay and do your work in the support base, it’s a lot easier, you’re less under pressure” (Brad).

“My tutor will give me a big hug and then let me calm down in her office” (Daisy).

“I’ve got Miss Roberts, because she’s the one that like, actually listens” (Cassie).

A number of children discussed negative experiences of support from school-based professionals throughout their school life, although some of these were related to a previous school setting.

“We’ve been pushed away when we’ve asked to speak to someone, we’ve been told ‘just don’t worry about it, just go to lessons and see how you feel after’, we’ve just been shut down when we needed help the most” (Chloe).

“The only reason I don’t [seek support] is because I’ve been bullied since I was in nursery, so I don’t really feel safe anywhere” (Ashley).

5.3.2.3 Trust

Some children felt they didn't have an adult in school that they felt comfortable talking to, with a lack of trust being a common reason as to why.

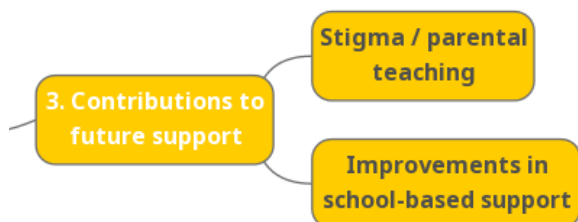
"I don't think I could go to any of the teachers in this school I think they are all like snakes. I don't trust any teachers in this school" (Darcy).

"I've had a bad past, I don't wanna talk about it, but it's basically made me push everyone away because I used to have someone I trust, and then they betrayed me" (Beth).

Confidentiality appeared to be important across both of the groups interviewed. Children raised concerns about other's knowing about their situation and the support they access.

"People always want to know your business, like when you get notes to go places they are like 'oh where do you have to go?' and when I say I don't wanna tell them they say 'tell me I won't tell anyone'" (Cassie).

5.3.3 Contributions to future support



5.3.3.1 Stigma / parental teaching

A number of children discussed the stigma surrounding vulnerable groups in their secondary school, with some suggesting that more education about mental illness might prevent stigma and bullying in the future.

"I got teased because I was walking over to support base to get something and they were like 'look you're a little freak, you just came out of support base'" (Beth).

"I think if maybe they are just taught about all the mental illnesses, I think it would help to prevent [bullying] in secondary maybe" (Darcy).

“If people knew what other people had to go through at home, then there wouldn’t be things like bullying... people would take more care in what they’re saying” (Daisy).

The children also discussed their experiences of adults fuelling stigma around vulnerable groups and highlighted the need for such adults to have a better understanding.

“...even the parents, there is this boy who was adopted, he’s had quite a hard life from the beginning and my sister in law, she’s like, “he’s a bit weird... he’s a bit strange isn’t he? ...he’s really naughty”... That’s why people don’t have the understanding because all their life they have been told “stay away from the kids that, you know, don’t fit in as much” (Chloe).

“...if kids were taught in primary, they could be to their parents “Oh, well the teacher’s told me that they’re a little bit different, they’ve got something else going on, but it’s okay to be different...” (Annie).

5.3.3.2 Improvements in school-based support

On the topic of improvements to school-based support, children made a number of recommendations, drawing on their own memories of effective teaching and support. Children mentioned the importance of learning more about emotions, both good and bad, through visual and practical experiences.

“you could have someone that suffers from [mental illness] go in to school and talk about what it’s like and how it affects you on an everyday basis” (Brad).

“I think for kids it’s all about visual learning isn’t it? Puppets, videos, stuff like that, even plays. I used to get a lot from that and I still remember now” (Daisy).

“I feel like in primary, emotions are key, you learn a lot about emotions so maybe stating bad emotions, stating what emotions can do to you...” (Chloe).

“it’s okay to feel bad emotions...” (Annie).

Linked back to children’s own experiences of positive school-based support, they also discussed the importance of places to ‘escape’ when things become overwhelming both in school and in their everyday lives.

“I think just a little building for all those people that are, feeling like it’s way too much and they can just go somewhere and forget about it. Just to relax” (Brad).

“A room that you could just go in and just sit and you don’t have to talk to anyone about anything...” (Daisy).

Some children identified a need for an extended period of time away from responsibilities.

Chloe (to Beth): “Do you think going away for residential is more effective than like an hour speaking to somebody?”

Beth: “It’s a bit more effective because it helps get my mind off it for longer”.

5.3.4 Collective identity

4. Collective identity

Despite the children not knowing each other before the group interview, the year 11 group very quickly appeared to form a collective identity, with children making reference to a collective ‘we’.

“If somebody was put in to any of **our** shoes, it would be really hard to handle but... **we’ve** all adapted to it” (Chloe).

“**We’ve** been shown **we** can’t trust” (Darcy).

“**We’ve** been shown the worst. And now this is where **we** are, feeling like **we** can’t even confide in somebody” (Chloe).

The children began nodding and agreeing with each other’s comments, reflecting back what others had said, particularly in relation to challenges and difficulties, with a sense of coming together to express frustrations and injustices.

Darcy: “and [teachers] don’t care do they?”

Annie: “they don’t care”.

A sense of collective identity was also evident in the year 8 group, but more in relation to an ‘us’ and ‘them’ attitude (carers/non-carers or experiencers/non-experiencers). When referring to the ‘Who Cares?’ project, Brad commented:

“it’s raising awareness and basically showing **them** that it’s not easy”.

5.4 Phase 2a Discussion

In this section I will discuss the phase 2 findings in relation to the research questions for phase 2a, with reference to relevant literature.

5.4.1 Impact of mental illness within the family on children

This section is relevant to research question 4: How do COPMHN perceive their additional social, emotional and mental health needs? The children interviewed referred to their lived-experience regarding the impact of familial mental illness. These children noted additional responsibilities, a negative impact on their own mental health, a need for respite opportunities and the need to feel in control. These perceived needs have implications for support.

Research previously discussed highlights the confusing, stressful and traumatic nature of living with and/or caring for a family member with mental illness (The Children's Society, 2008b). The children interviewed often referred to caring responsibilities and the stress and emotional strain that this can cause.

Research by Evans and Fowler (2008) suggests that often COPMHN must demonstrate maturity beyond their years, dealing with medication and providing emotional support, which can have a negative effect on their school work and social lives. Such responsibilities were reflected in the comments made by the children in this research.

The SCIE guidelines (2009) highlight that children caring for a parent with a mental illness are likely to require social support in relation to their additional responsibilities and the impact of these. However, the children interviewed report inconsistent support in relation to their needs, with some highlighting that they do not feel adequately supported by professionals. Others discussed that their parent's mental health needs were not supported appropriately, leaving the children to deal with the consequences of this. This finding therefore highlights a need for support in relation to the additional responsibilities that these children face. This however relies on identification of COPMHN by those supporting them and an understanding of how their home lives can affect their wellbeing.

A number of the children interviewed expressed having mental health needs of their own, despite this not being a pre-planned topic of discussion. A child's mental health needs may be an impact of living with a parent with mental

illness, in line with the notion of an intergenerational impact (Johnston et al., 2013). Cooklin (2013) discusses a universal need for children to make sense of their parent's behaviour. In attempting to understand the behaviour and thought processes of a parent with mental illness, children's own thinking and emotional development can be disrupted, when their interactions and communications with their parent do not make sense (Cooklin, 2013). Reupert et al., (2012) highlight the increased likelihood of COPMI developing mental health needs of their own, as a result of various genetic, individual, family and environmental risk factors.

The children interviewed reported a number of anxieties relating to their future. These worries were reported to result in a self-fulfilling prophecy, whereby worries about their situation affected their ability to engage in their education, which led to further worries about being behind with academic work and worries about the future. Similar difficulties have been highlighted by Cleaver et al., (2011), which suggest that COPMHN experience difficulties in education and often a loss of education due to emotional distraction and stress. It is important to recognise the impact that this may have on motivation and ability to engage in school-based activities and consider the support implications of this. This research suggests COPMHN may have emerging mental health needs of their own, which appear to be relating to caring responsibilities. This finding highlights a need for mental health support services to be available to these children in schools. It is also important to consider the therapeutic needs of these children throughout their education.

One focus group participant (Annie) felt that academic achievement was the primary concern for some teachers and that they did not always consider the difficult circumstances for some children that could impact on attainment. This highlights the difficult position of school staff when they are judged predominantly on the attainment of their pupils. This finding mirrors previous research findings suggesting that schools operate with high expectations for academic success which can counter a wish to support individual pupils in relation to mental health and wellbeing needs (Brownlie, 2014). A recent update to Ofsted's inspection framework (Ofsted, 2019) allows for the recognition that schools are supporting pupils as best they can, taking account of challenging circumstances. This development may relieve some of the

pressure for teachers that may feel the need to consider academic attainment above all else, even for the most vulnerable groups.

Respite opportunities have been highlighted as an important support consideration for COPMHN (Reupert & Maybery, 2007) due to the impact of parental mental health needs. Children in the current research referred to the importance of having time and space to compose themselves when they are having a difficult time and spoke highly of respite opportunities. Children interviewed discussed the importance of extended periods of time away from their everyday lives to experience freedom from their responsibilities.

Children interviewed referred to the need to appear strong and capable and expressed discomfort with displaying vulnerability or a lack of emotional control. This has implications in terms of accessing support, in that these children are unlikely to admit they need help. A comparable finding is reflected in other research by Becker (1995), highlighting a controlling nature as a possible outcome associated with being a young carer. Research by Foster (2010) suggests that the need to control for COPMHN is common, often due to feeling unsafe in the home environment.

Participants' comments reflect that having emotional control and being strong and reliable may be a key component of their identity as young carers/COPMHN. In the often-chaotic world of mental illness, it may be that these children seek to control the aspects of their lives they are able to. Admitting the need for help may therefore be detrimental to their self-concept, challenging the belief that they can take control of their situation. It may be that the thought of needing help or support creates cognitive dissonance, whereby their thoughts and feelings about support are inconsistent with their attitudes and beliefs associated with their young carer identity. Some of the children were negative in their discussions of support available to them as young carers and presented the narrative that they could not be appropriately supported by someone who did not have lived experience of what they had been through. Cooklin (2013) highlights that often, COPMI can feel patronised by professionals, which is something they strongly object to. It may be that this also challenges aspects of their identity relating to being strong and capable. It is important to note that the above discussion is my interpretation of the comments made and was not made explicit.

This finding highlights the importance of professionals supporting COPMI to be aware of a possible need to feel in present as strong and capable and feel in control. Support for this population should therefore be planned alongside the children themselves, utilising person-centred/family-centred planning principles.

5.4.2 Experiences of support

This section is relevant to research question 5: How do COPMHN perceive the support available to them in schools? The children interviewed spoke in detail about both positive and negative experiences of school-based support. Children referred to the importance of those supporting them having a genuine understanding of their situation and the potential impact. They also discussed people and places that they can access for support. Trust was identified as a difficult concept for some children, with a common theme of mistrust emerging from those interviewed.

Understanding was a central theme throughout the group interviews, with a consensus that the key to effective support arises from an understanding of, and respect for, COPMHN's circumstances. Children referred to effective support in relation to understanding and empathetic responses from professionals who make time to listen. Negative experiences of support were based on a lack of understanding or consideration from others in relation to COPMHN situations, as well as a lack of predictable, responsive and consistent support. Children also discussed some unhelpful responses in times of need, that they felt minimised the seriousness of their situation. This finding is mirrored by research by Bruland et al., (2017) suggesting that school-based professionals often don't know how to approach situations involving parental mental illness. This finding again reinforces the importance of increasing awareness and understanding of vulnerable groups. It is important to note that often COPMHN felt that the very nature of their caring responsibilities meant they could not always access the people and places set up to provide support for them. This is therefore an important consideration in the planning and implementation of future support.

Previous research highlights that COPMI can experience bullying (Grove et al., 2013), reflecting a lack of empathy and understanding from peers. Findings

from the current research reflect this experience of a lack of understanding from peers in general, but also from friends. This finding highlights a need for increased awareness and understanding of parental mental illness and mental illness more generally, in order to build capacity for peer support. The majority of children interviewed did however speak positively about support from peers who have had similar experiences to themselves as preferable to support from adults. This further highlights the importance of providing social opportunities for children who have shared experience of parental mental illness.

A number of children spoke of the importance of a place to go in school when they are experiencing difficulties in relation to their situation, where they could either talk to someone or be alone. Despite their apparent need to access such a space, children discussed a stigma around accessing support in school, often reporting a negative reaction from peers in relation to accessing a support space. This finding supports previous research highlighting that children do not always seek help in school for their difficulties due to stigma (Bowers, Manion, Padadopoulos & Gauvreau, 2013).

Some children interviewed felt they had someone they could speak to in school if needed, but this was not the case for all children. Even when it was felt there were adults available, sometimes children did not feel able to approach them, as they felt they would be misunderstood, or because they did not have trust for such adults. Murphy, Peters, Wilkes and Jackson (2015) highlight a mistrust for others among those who have experienced parental mental illness. A lack of trust for others was a common theme in relation to support highlighted in the current research. One of the participants (Darcy) was reluctant to contribute to the discussions initially. She later contributed in relation to expressing distrust for others, based on her previous experiences. I therefore wonder if maybe she felt I couldn't be trusted initially.

As some of the children interviewed identified themselves as young carers, it may be that they have always been the ones that others rely on, and that previous experiences have reinforced the idea that they cannot rely on others to have their own needs met. It may also be the case that these children have had negative experiences of support over time, and they are now left feeling there is little point in accessing support available. This could be understood in relation to the notion of child learned helplessness (Evans, 2003), whereby children have

experienced so many failed attempts at having their needs met that they no longer persist at attempting to gain support from others.

I recognised that as the focus group discussion progressed, particular children were more eager to discuss negative experiences of support, despite previously expressing positivity about the support available to them. It is important to consider whether the more negative comments were made in order to conform to the direction of the group discussion, or whether they felt able to be more honest and trusting as the interview went on. I am inclined to believe the latter is the case, as these children were able to illustrate their comments with concrete examples, with their frustrations appearing to be genuine. These observations have implications for support, as they highlight the importance for those supporting this group to take time to build up a positive, trusting relationship with these children. This also has implications for future research, when attempting to explore the thoughts and feelings of this vulnerable group.

5.4.3 Contributions to future support

This section is relevant to research question 6: What support do COPMHN of secondary age think could be implemented for their group in schools? Children are experiencing increasing pressure in schools and a lack of time for individual support and response from teachers as a result of the accountability agenda in England (Hutchings, 2015). The most damaging effects of this are on disadvantaged pupils, who are still expected to follow the same curriculum and achieve in line with national levels regardless of their needs and circumstances (Hutchings, 2015). Children experiencing parental mental illness report having additional difficulties and conflicting responsibilities. This current research shows that these children can find the school environment particularly overwhelming and would benefit from increased support and respite opportunities.

Children interviewed discussed possible ideas for future support for COPMHN in schools. Often children used their own experiences of positive support discussed previously to inform their ideas. Key themes related to the importance of educating both children and adults about mental illness to reduce stigma and supporting younger children in schools to begin to understand the

foundations of mental illness. Some children referred back to the importance of a designated space to use when things became overwhelming in school and the importance of people who understand their situation.

In relation to improvements for the future, children referred to the importance of increased education for children from a younger age. interviewees felt that in teaching children about mental illness in an age-appropriate way from a younger age and addressing misconceptions, it may prevent some of the teasing and bullying that they have witnessed or experienced. The importance of psychoeducation in mental health is widely discussed in the literature (Cooklin, 2013). Children in the current research made specific reference to the importance of visual and interactive experiences to educate children about important topics, emphasising the memorability of such learning. One child (Annie, year 11) discussed the importance of teaching younger children that it is okay to feel bad emotions. I question whether this was something missing from Annie's education when she was younger, considering the comments she also made in relation to the need to present as strong and capable. It is possible that Annie wasn't provided with opportunities to learn about dealing with negative emotions as a child, which has had an impact on her coping strategies as an older child. This also links in with the lack of trust for others previously discussed. If these children do not feel able to trust others or rely on them for support, an alternative option for survival may be a facade of strength and independence, as they may feel it is not okay to appear vulnerable.

A number of children discussed their experiences of stigma surrounding vulnerable groups being passed on to the next generation, due to a lack of understanding from parents, and felt this needed to be addressed. Children discussed their experiences of parents telling their children to "stay away from the kids that... don't fit in as much" (Chloe, year 11), due to a lack of understanding and empathy about the difficult situations of others. I conceptualise this as an 'intergenerational cycle of misunderstanding'. Hinshaw (2009) discusses the notion of the ongoing stigma around mental illness and posits that "a far brighter future will emerge when knowledge replaces ignorance" (p. 17). Children's comments reflect this idea that education is the main route to reducing stigma. Some children referred to the possibility of a bottom-up approach, whereby children educated in schools might be able to

support their parent's understanding of the difficulties faced by vulnerable groups and how they might be supported.

Relevant to support for the future is the theme of a collective identity for COPMHN, which was a theme arising from the current findings. One theory is that the formation of a collective identity supports a sense of belonging to a group. Themes from phase 1 and 2a reflect feelings of social isolation and stigma; therefore, I suggest that this collective identity could provide children with a sense of belonging, supporting them to feel less alone in their situation, as highlighted in other research by Wadey (2015). Being part of a group whereby similar experiences can be shared openly, might also allow for children to make sense of their own experiences more easily.

The formation of a collective identity might also provide a platform for potential collective action (Van Zomeren, Spears & Leach, 2008), which is likely when group identity facilitates group-based emotions such as anger, based on group-based appraisals such as unfairness. Research suggests that found that if there is a strong relevance for group identity, this can overpower any feelings that that group may have about a lack of group-efficacy to affect change (Van Zomeren et al., 2008). Both strong emotions and feelings of injustice were expressed by interviewees in the current research. The experiences discussed by those interviewed generally became more negative as the focus group progressed. Children who hadn't previously contributed appeared to feel more able to contribute as the group identity appeared to form. This could be due to children feeling more able to express their views, as a result of increased group identification, reflected by the social identity model of deindividuation (Reicher, Spears & Postmes, 1995). This could also be due to an increase in trust for me as an interviewer, or conformity to the nature of the discussion as directed by other interviewees. Although children did appear at times to be frustrated by their situation and the lack of appropriate support available, some children displayed a sense of helplessness in relation their situations. Bearing in mind the aforementioned research regarding group identity (Van Zomeren et al., 2008), providing children with opportunities to come together and support one another might therefore result in the group feeling more able to express their needs and frustrations, and feel more empowered to take action to make things better for themselves.

5.5 Phase 2a Summary

The findings from phase 2a of my research highlight a number of perceived difficulties and additional needs for secondary school children experiencing mental illness in their families. These children noted additional responsibilities which often conflicted with school-based and social expectations. These children often recognised a negative impact on their own mental health and an increased need for additional respite from their responsibilities. These children also recognised a need within themselves to present as strong, capable and in control in the face of difficulty.

In relation to their experiences of support, children often felt strongly that a genuine understanding of their needs as COPMHN was key to empathetic and appropriate support. However, these children often felt let down, misunderstood and unsupported by professionals and peers. Children often felt that the impact of their situation was underestimated by those around them, leading to unhelpful suggestions. The children interviewed made reference to the importance of key people to whom they could approach for support, although not all children felt they had such a person in school. Children interviewed referred to the importance of 'safe' spaces to go in school when experiencing difficulty in order to access support or regulate themselves emotionally. Trust was raised as a key aspect in relation to accessing support, with many children reporting a general lack of trust, based on their previous experiences.

In relation to future support, children highlighted a need for increased efforts by schools to reduce the stigma associated with mental illness and additional needs generally, as this was something they still experienced in their everyday lives. Children emphasised the need for increased education and understanding around poor mental health, and the importance of promoting the message 'it is okay to feel bad feelings'. Children interviewed often felt strongly that they would like a place to be able to go in school when things are particularly difficult at home, or when they are finding the school environment overwhelming and need some time to be calm.

Children interviewed within the group situation soon appeared to form a sense of collective identity. It is likely that this was brought on by the sharing of similar experience and connecting with others who appear to understand the difficulties

associated with familial mental illness.

Chapter 6: Phase 2b

6.1 Phase 2b overview

Phase 2b was an exploration of the views and experiences of school SENCOs in relation to their knowledge and experience regarding COPMHN and their capacity for supporting this group. In this phase I used semi-structured interviews to explore the views of five SENCOs from the Southbridge area.

6.2 Research aims and questions

Research Question 7: How are the needs of COPMHN perceived by school staff?

Research Question 8: What support is currently available to support COPMHN in primary schools?

Research Question 9: How do school staff feel support for COPMHN could be implemented in schools?

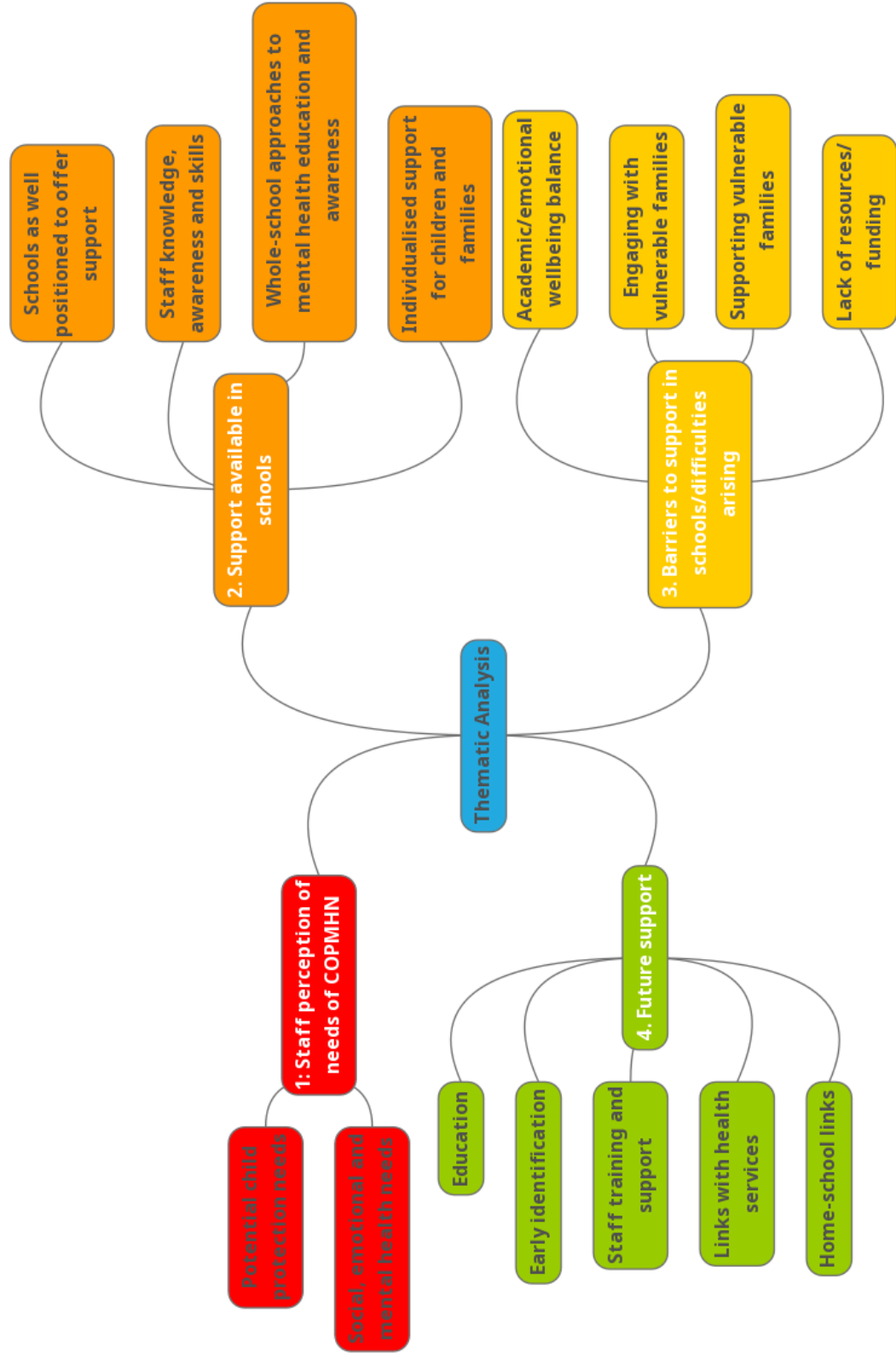
Research question 10: What are the barriers to supporting COPMHN in schools?

6.3 Phase 2b Findings

In this section, the findings from phase 2b will be presented. Global themes will be presented and discussed in relation to the subthemes that contribute to them. Illustrative quotes from participants are also provided. Figure 4 shows the global themes and subthemes for phase 2b.

Figure 4:

Thematic map illustrating the global themes and subthemes for the phase 2b data.



6.3.1 Staff perception of the needs of children of parents with mental health needs



6.3.1.1 Potential child protection needs

SENCOs recognised that COPMHN were at a heightened risk of abuse and neglect in relation to parental mental illness in the family.

“We are always hypervigilant of that child’s child protection needs” (Charlotte).

SENCOs often referred to their own professional experiences of child protection concerns in relation to a parent’s mental illness for children in their school setting.

“As a result [of not accepting support], their child is being emotionally abused at the moment, so social care are involved, but it’s [not] meeting the thresholds, but we can see the damage it’s causing to the child” (Lisa).

6.3.1.2 Social, emotional and mental health needs

All of those interviewed referred to the social, emotional and mental health needs that can be experienced by COPMHN. SENCOs often referred to some of the reasons why children might present with these needs.

“Quite often, there will be a clear need for control...possibly, because at the home the environment is erratic... if parental responses aren’t clear and consistent. You don’t know what response you’re going to get from your parent, so you start building a need to control your life... Our children can’t express that, so they show us through some, sometimes very challenging behaviours” (Charlotte).

“I would say how we tend to know... is through the behaviours of the children. Looking at those little signs that help us to build up a picture of okay, what is going on for the parents?” (Tanya).

SENCOs often recognised the need to meet the social and emotional needs of COPMHN before these children are able to focus on their learning.

“If you come in to school stressed and upset, and not able to cope with anything then you’re never going to learn...” (Laurie).

“That has always been my argument, they are not going to learn unless they feel safe and secure” (Lisa).

SENCOs were able to notice how parental mental health needs might impact on the child’s opportunities and experiences, their perception of the world and their own mental health needs.

“...their own mental health, their own experiences, their own access to play, relationships, friendships, if they have to be a young carer and their perception on the world, living in a world where mum stays on the sofa” (Tanya).

“Some children are super good for a reason, and they are super good because it keeps everything on an even balance” (Charlotte).

Some of those interviewed noted the additional difficulties often faced by COPMHN, that may further contribute to or perpetuate their needs.

“Social deprivation and mental illness are interlinked to a greater or lesser degree” (Vanessa).

“A lot of [COPMHN] end up becoming a carer, so they’ve got that additional responsibility, so we give them the TLC that they need in school” (Lisa).

6.3.2 Support available in school



6.3.2.1 Schools as well-positioned to offer support

Reflected in SENCOs comments was the idea that schools were a central part of their local community and were well-placed to provide a wide range of support to children and their families.

“The school is the community and the ‘hub’” (Tanya).

“We laugh and call us the ‘one stop shop’ at the moment because everyone comes to the school. We provide counselling, we provide play therapy, we provide wraparound care...” (Lisa).

SENCOs all referred to the idea that schools are in a position to get to know children and families very well and can ‘build up a picture’ over time. Therefore, they are able to notice changes in behaviour that may require additional exploration and support.

“Me and my class are together all of the time, so you can build up that picture... I can tell what kind of morning they have had by what their parents are like with them” (Laurie).

“The child was the presenting issue, but the more we work with the family, the more we realise it’s not actually her issue at all, it’s the parent’s” (Vanessa).

SENCOs also noted that: “it can sometimes take a couple of years to actually know the depth of mental health needs” (Tanya).

SENCOs also mentioned opportunities in schools for incidental teaching in relation to mental health in order to embed some of the learning and linking it to the children's experiences.

"I spoke to my class about it today and they are all a bit narky with each other because it's the end of term and it's a Monday, and I was like, let's go back to this (mental health display) and talk about this" (Laurie)

"[We] unpick it a little bit. Asking "how does your body feel when you are sad?" and actually recognition that you can be sad in different ways" (Charlotte).

SENCOs often discussed the way in which schools often promote open communication with parents, in order to better understand and support the children in their schools.

"We have a pre-school interview with the parents and basically start making it clear to those parents that we do ask the difficult questions. We ask them questions around ACEs at the start" (Charlotte).

"We have a really good system in foundation where the parents are invited in to school and they do a lot with the children in school. That gets parents quite confident to come in" (Vanessa).

SENCOs also referred to links with external support services, including the local multi-agency support team, CAMHS, social care services, other charity-based services and other schools in the community.

"We have a lot of support for mental health in school from the multi-agency team... We employ counsellors and learning mentors" (Vanessa).

"We also tap in to other agencies like the family intervention project and they support families to do with mental health" (Tanya).

"We signpost wherever we can and if I can't think of anything, I'll call up another school" (Lisa).

6.3.2.2 Staff knowledge, awareness and skills

The majority of SENCos referred to wide-ranging skills evident within their staff in school. Many of those interviewed were from schools that had received 'ACE Lens' or 'trauma-informed schools' training.

"We have a range of staff with a range of skills. I think we have a lot of unconsciously competent people here" (Charlotte).

SENCos often referred to the key role played by family liaison and parent support staff in their schools in supporting the needs of vulnerable children and families.

"We have a parent support adviser, who is also a children and families coordinator who has years of experience working with families..." (Tanya).

"[our] family liaison will check in with parents. She is outstanding. She gets those hard to reach parents... She will go to appointments with the parents, she'll get parents in, she'll taxi parents, she'll sort their finances out" (Lisa).

6.3.2.3 Whole-school approaches to mental health education and awareness

The majority of SENCos interviewed referred to the idea that their approach to mental health and emotional wellbeing was part of the whole school ethos and approach, enabling support to be put in place. SENCos also referred to the overall environment and atmosphere of their school as being conducive to support.

"I think it's part of the whole package of what we do. It's because of the ethos we've got that enables that to happen. We have so many staff meetings on ACEs, so many staff meetings on THRIVE and supporting children with feelings and behaviour" (Charlotte).

"There's a whole lot we can do in school through the support we have and just the whole school atmosphere, where a child can have those positive nurturing relationships" (Vanessa).

SENCOs commented on certain school practices, projects and whole school messages that were reflective of the wider school ethos previously mentioned.

“We have mindfulness in every class twice a day and we talk about using it to ‘give your brain a rest’...it’s okay not to be okay, and it’s okay to not know why” (Charlotte).

“I’ve been in with children this morning making emotion monsters, I do think it needs to be explicit, school is the place to do it” (Tanya).

For one SENCO (Vanessa), she felt that a focus on mental health and wellbeing was a “new area” of attention in her school.

6.3.2.4 Individualised support for children and families

SENCOs also acknowledged more specialist provision available to the children identified as in need of some additional support.

“We’ve got a level where everyone should be, with the nurturing environment, but then we’ve got the level of ELSAs, learning mentors, counsellors...” (Vanessa).

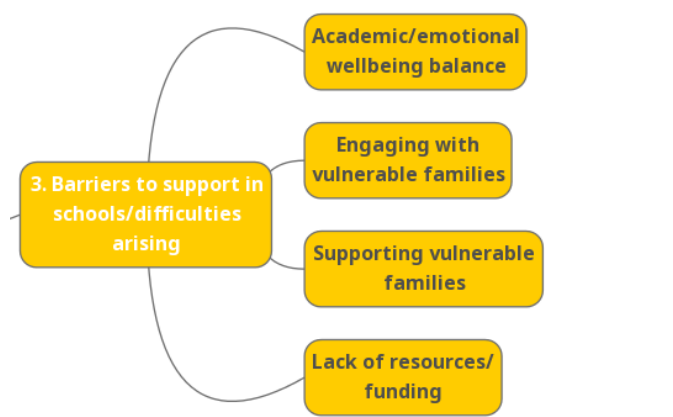
“It’s about going that extra mile for them... for the more vulnerable children” (Lisa).

Almost all SENCOs referred to nurture provision available to particular children at break and lunchtimes. Some SENCOs also commented on support for parents and whole families offered by their school.

“We also have play therapy in school and parents have come in and joined in sessions, whether that’s with a learning mentor, or ELSA” (Tanya).

“We have a counsellor here who will see parents at lunchtime. So, we offer that for free” (Lisa).

6.3.3 Barriers to support in schools/difficulties arising



6.3.3.1 Academic/emotional wellbeing balance

All SENCOs interviewed referred to the difficulties implementing support for vulnerable children due to the increasing demands of the curriculum, and Ofsted's focus on academic progress and achievement.

“At the end of the day, we’ve got to turn out children that can read, write and do their maths and we’re not judged on how happy they are...” (Laurie).

“I would say the time that we are doing art and creative sorts of things is limited by the curriculum, Opportunities [for] group work and collaboration just doesn’t happen anymore and I think that’s a real detriment to children... Our whole school focus is our basic skills and literacy and numeracy and Ofsted coming” (Vanessa).

6.3.3.2 Engaging with vulnerable families

SENCOs all identified the difficulties in identifying parental mental health needs, suggesting that parents do not always come forward and provide this type of information of their own accord.

“We don’t know them all [COPMHN], we need to see the communicating behaviour to know that” (Charlotte).

“We have a few whose parents aren’t [forthcoming], those really hard to reach parents, but we try and reach them and that gives us a message as well” (Vanessa).

SENCOs also reported that sometimes the most vulnerable families are reluctant to engage when support is offered, recognising that this may be for a number of reasons.

“there is a trust issue as well there isn’t there?” (Laurie).

“Whatever support we tried to offer mum; she was really resistant” (Vanessa).

“The parent would not engage, and you can only try so many times... if they’ve got low self-esteem, if they’ve got anxieties, we can’t expect them to come in to the building and be around others” (Lisa).

SENCOs often felt that sometimes parents were difficult to engage in the right kind of support, as they did not yet recognise and/or accept the impact that they may be having on their child. SENCOs felt that sometimes these parents would attribute difficulties to be within the child themselves and seek support on the basis of this understanding.

“Sometimes they will come in to ask for support, not for them, but for their child really... the more you talk to them, the more it becomes clear that it’s not necessarily the child, who’s got a difficulty but it’s how they are being parented and the whole atmosphere at home really. The parent’s either don’t know [they have a mental health issue], or they’re not going to ‘go there’. We can support the child in school but it’s almost like a sticking plaster” (Vanessa).

SENCOs also commented on the difficulty that some people still have in discussing mental illness, possibly associated with stigma.

“It is awkward, it’s kind of got to come up naturally in conversation, there is no way I would ever say to a parent ‘so have you got mental health issues?’” (Laurie).

“I think with the ongoing stigma, the size of the community is an issue” (Charlotte).

“I don’t think there is the stigma here, I think in the community there is, within our school there isn’t” (Lisa).

6.3.3.3 Supporting vulnerable families

SENCOs often commented that when they are able to engage families in communication and support about their difficulties, there can sometimes be deeply embedded parenting issues that can be a barrier to support.

“A lot of [the support requests] are around, I’d say the fallout that children have, where their parents have a mental health issue or things that impinge on their ability to parent supportively” (Vanessa).

SENCOs often felt that despite being able to offer support to parents in relation to their children, they did not consider some aspects of parent support to be their role or remit.

“...we are kind of stepping in as parents aren’t we? Some of that is to do with mental health stuff... some of that is to do with lazy parenting” (Laurie).

“The parents are completely neglectful, they don’t take him to appointments, and now he’s struggling. We do so much for the parents but actually you’ve got to think... you’ve got to do something now. There is a case for getting the parents to be independent as well. at some point the parents have got to be resilient themselves” (Lisa).

SENCOs commented on the difficulties arising in supporting parents whilst maintaining the child’s needs as the priority.

“You also need to make sure that the professionals supporting the children don’t become so involved with the problems of the parent, that they forget to look at the impact on the child” (Charlotte).

“It is really difficult with those who you know have mental health issues, you know it’s impinging their child” (Vanessa).

SENCOs commented on a lack of involvement and support from health services at times. Some SENCOs felt that health services should also be thinking more holistically about a patient or client they are working with, to consider others that might be affected.

“We are pretty good as a school at CAMHS being our last resort. People assume that once you’ve got them in, they are going to do something...9.5 times out of 10, there is nothing” (Laurie).

“We try and get CAMHS involved but the waiting list on that is usually too long” (Lisa).

“I think GPs, CPNs are under as much pressure as anybody else, they see that person, they don’t see... the other people, the family that are impacted by what’s happening. I do think school have a role, but I also think health have a role. Parents are not accessing services other than their GP, taking medication” (Charlotte).

Some SENCOs commented on a lack of communication and collaboration between schools and health-based services, resulting in ‘disjointed’ support, a lack of holistic understanding about a situation and possible safeguarding concerns.

“Its really disjointed. The GP refers in, then the CAMHS team arrange a meeting here with parents. So, I’m sat in some meetings thinking ‘I have no idea what you’re talking about’...” (Laurie).

“[There have been] serious incidents where professionals hadn’t got together and shared that information, hadn’t highlighted just how difficult life was for this child and that’s our deepest fear” (Vanessa).

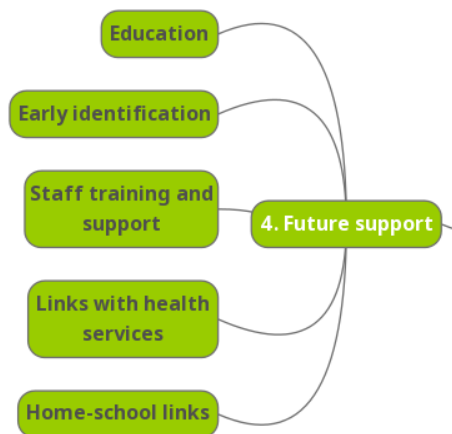
6.3.3.4 Lack of resources/funding

All SENCOs commented on the impact of a lack of resources and funding on the ability to implement support for vulnerable children and families both within school and in other services.

“It all comes down to finances and social care and the NHS, we are all short of money” (Vanessa).

“When funding is cut, the first thing to go is the pastoral. The first thing they lose is the TAs. The first thing they lose, is the listening” (Lisa).

6.3.4 Future support



6.3.4.1 Education

SENCOs generally felt that primary schools could be the place to teach children about mental illness in an age-appropriate way, however no-one felt that their school currently taught about mental illness explicitly.

“I definitely think that it’s becoming more of the school’s responsibility to do that stuff” (Laurie).

“I think children naming it and us being more explicit will be a barrier to overcome” (Tanya).

6.3.4.2 Early identification

SENCOs comments reflected the need for early identification of children experiencing difficulty. They often commented that children may not recognise that they are experiencing difficulties or cannot communicate this effectively to someone who can offer support.

“How can we get children to talk about it? Because that’s how we would be able to get under the tip of the iceberg” (Charlotte).

“Something like ‘Kendra’s list’ would raise the profile and absolutely make it okay to talk about.... it’s giving children the language and vocabulary about what is okay and what isn’t okay... it would empower staff to have those conversations and be more confident” (Vanessa).

6.3.4.3 Staff training and support

SENCOs often referred to the increasing responsibilities that some school staff take on with regard to supporting vulnerable children and families, without having the necessary training. When discussing some of the needs of parents with mental health needs, one SENCo (Laurie) commented: "... our PSA isn't trained to do all of that". Other SENCOs made similar comments:

"Sometimes I think the least qualified people in school are asked to do things" (Charlotte).

"It seems like everybody is having to step up and do more than you necessarily thought was your role. If you're talking about the whole child, then [supporting families] is your role" (Vanessa).

"School staff want to know about strategies they can use to support. Always practical advice. They just want to make it right for the child" (Lisa).

Some interviewees identified the need for ongoing professional support and supervision for school staff in relation to their evolving roles.

"The more we deal with this kind of stuff, the more professional supervision I think we need" (Laurie).

6.6.4.4 Links with health services

SENCOs commonly referred to the need for improved links between schools and mental health support services.

"That parent obviously needs some psychological support and some social support and that's more than we can do. We would like to have better links with CAMHS and mental health services, but I don't think that's going to happen" (Vanessa).

"I find one of our biggest challenges is getting the health professions working with us ... I think some of [the support] needs to come from health working" (Tanya).

"... 30 years and we are still trying to get health and education working together. Like the EHCP... what does it all boil down to? Education. Where is health? Where is social care? It doesn't happen" (Lisa).

6.3.4.5 Home-school links

The importance of establishing home-school links and building relationships with parents was highlighted by those interviewed.

“It’s trying to get over that stigma and inviting parents in in a non-threatening way and building those relationships” (Vanessa).

“What’s the real deal? What’s really going on and what’s really happening? and it’s about building those relationships as well isn’t it?” (Laurie).

Some SENCos commented regarding support already in place in their schools to promote these links, most notably through the work of family liaison and parent support staff previously discussed.

6.4 Phase 2b Discussion

I will now discuss the global themes and subthemes in relation to the four research questions presented for phase 2b, alongside relevant literature.

6.4.1 Staff perception of the needs of children of parents with mental health needs.

This section is relevant to research question 7: How are the needs of COPMHN perceived by school staff? Those interviewed described the primary needs of COPMHN in relation to potential child protection needs and social and emotional needs. Based on findings from relevant literature on the impact of parental mental health on children, the SENCos interviewed reflected a reasonable overview of the common needs of this vulnerable group. Staff were also able to identify aspects of the child’s home lives and parental behaviour that may contribute to a child’s difficulties. SENCos often highlighted barriers to meeting the needs of COPMHN in school.

SENCos interviewed often recognised the association between parental mental health difficulties and children’s safety, health and wellbeing (Blewett, Noble & Tunstall, 2010). Research has indicated that parental mental health problems feature in just over half of serious case review incidents (Sidebotham et al., 2016), highlighting the importance of COPMHN being identified early and

supported effectively. Serious case reviews have suggested that professionals sometimes lack awareness of the severity of a parent's mental health problem and may not understand how this affects their capacity to parent their children (Brandon, Sidebotham, Bailey & Belderson, 2011). The SENCos interviewed for this research *did* appear to be aware of the safeguarding risks associated when a parent has a mental health need or illness based on parenting issues and the home environment generally. SENCos did however have concerns around social care intervention and thresholds when children were identified by school staff as 'at risk'. This will be discussed later in relation to barriers to support.

SENCos were able to recognise that a child's challenging behaviours were likely to be communication of an underlying difficulty and that COPMHN may present with social, emotional and mental health needs. SENCos felt that the child's behaviour was often the first indication of parental mental health needs, prompting further exploration and communication with parents by school staff. This highlights that parents don't usually come forward and provide information about their mental health needs to those supporting their child. The SENCos suggested that this was often because they: did not acknowledge their own needs, they did not acknowledge the impact of their own needs on their child, or they felt that their own needs were due to their child's difficulties. These difficulties were highlighted as barriers to support, which will be discussed later in this section.

SENCos noted that COPMHN were at risk of becoming young carers, as is highlighted in the literature (Bilsborrow, 2004) and recognised the impact that this may have on a child's opportunities to access support outside of school. SENCos could also recognise that mental ill health is often a feature of families living in adversity (Falkov et al., 2016) and hence acknowledged a range of other challenges that these children might face.

SENCos often commented on the need to meet the basic needs of COPMHN, before expecting them to be able to learn. In line with Maslow's hierarchy of needs, SENCos referred to both physical and psychological needs that, if not met, impinge on a child's ability to engage meaningfully and effectively in learning and reach their potential (Maslow, 1943; 1954). Despite this understanding, some SENCos felt that the demands of the curriculum and a

strong school focus on academic achievement and outcomes prevented staff from supporting children effectively in relation to their more basic needs at times. This will be discussed further in relation to barriers later in this section.

6.4.2 Support available in schools

This section is relevant to research question 8: What support is currently available to support COPMHN in primary schools? SENCOs highlighted a wide range of support provided by their primary schools for vulnerable children and families. SENCOs were less aware of support specifically for COPMHN, however they were able to recognise how these children could access support relevant to their potential additional social, emotional and mental health needs.

Schools are increasingly expected to support the needs of children outside of the more traditional academic and progress priorities, in relation to their mental health and wellbeing (Department of Health and Social Care & DfE, 2018). SENCOs interviewed often talked in great length and detail about schools as being well placed to offer support to vulnerable groups. They noted some specialist skills and training amongst staff, whole school and individualised approaches, as well as links with more specialist services who can provide extended support to children and families. A large majority of the SENCOs interviewed were from schools that had received 'trauma-informed schools' training or ACE training and hence felt that their staff were generally very aware and understanding of how children's experiences can impact on their behaviour, and how best to support these children. Some SENCOs felt they would benefit from some more training and guidance in relation to supporting COPMHN and their families, with all SENCOs recognising the importance of regular continued professional development opportunities.

Jopling and Vincent (2016) posit that primary school teachers and school-based staff are well placed to identify and respond to the needs of vulnerable children at an early stage and link in with specialist support services. The authors highlight that compulsory education allows regular monitoring of vulnerable groups of children in a way that other agencies and services do not. SENCOs interviewed for the current research expressed a good understanding of the

needs of vulnerable groups of children and their families and made reference to the nurturing school environment and supportive structures in place. SENCOs agreed that as school staff also have regular access to the children, there are opportunities for them to promote education and understanding about issues such as mental illness and can reinforce this as incidental opportunities arise. SENCOs felt their consistent and regular contact with children allowed them to build an accurate picture of a child's needs over time and also enabled them to recognise differences in behaviour that may be a cause for concern, promoting early intervention opportunities (Durlak et al., 2011). SENCOs commented that sometimes it can take a long time to build up an accurate picture of a child's circumstances and understand the extent to which parental mental illness might be impacting on a child. This emphasises the unique position of schools to identify difficulties at the earliest stage.

The National Institute for Health and Care Excellence (NICE) advises that primary and secondary schools should adopt 'whole school' approaches in promoting the social and emotional wellbeing of their pupils. (NICE, 2008; 2009). Ecclestone (2012) posits that certain universal interventions preventing future mental illness can also target those with early problems. Well-coordinated and embedded whole school approaches to promoting social and emotional wellbeing is correlated with better outcomes, whereas small, fragmented and uncoordinated interventions are not (Banerjee, Weare and Farr, 2014). All of the SENCOs in the current research emphasised the importance of a whole-school approach to mental health and wellbeing initiatives and a nurturing school environment. The vast majority of SENCOs felt their school ethos did prioritise such initiatives, which made putting support in place for vulnerable children much easier. SENCOs highlighted the importance of support for such initiatives to be acknowledged, embedded and driven by a whole school ethos, with support from senior leadership. Such whole-school approaches to mental health and wellbeing rely on a genuine involvement from all staff, parents and the community and engagement with multi-professional outside agencies (National Child and Maternal Health Intelligence Network, 2011).

As well as the universal provision and whole-school approach to emotional wellbeing and mental health, SENCOs also commented on a range of support

provision and interventions available to children identified as in need of additional support. Some of these were facilitated by school-based staff with specialist skills and training. Others were supported by external professionals linked to the schools, such as learning mentors, counsellors, therapists and psychologists. As SENCOs tended to have a good understanding of the needs of COPMHN, they were able to recognise what kinds of intervention they might need. Ideas included: sessions with an emotional literacy support assistant (ELSA), learning mentor or therapist (play, art, drama), extra breaks and time out of lessons, extra 'TLC' and nurture provision during unstructured times.

Research by Weist et al., (2002) supports the positive outcomes of school-based support services in relation to parental mental health, suggesting they can reach more children, reduce stigma and provide greater access for families. SENCOs in the current research commented on schools as a 'hub' for the community, with easy access to a wide range of support for children and families. SENCOs highlighted the importance of building relationships with vulnerable families in particular, in order to open avenues for communication. SENCOs commented on a range of different strategies employed by their schools to engage parents in open communication about their family's needs, ranging from coffee mornings to art-based projects targeted at specific parents. Parent support advisers and family liaison staff were highly valued by the schools that employed them in relation to the vital role they play in engaging and supporting vulnerable and 'hard to reach' families and signposting to external services when needed, including the local multi-agency support team that provide the Kidstime intervention. Barriers to engaging and supporting vulnerable families were however identified and will be discussed later in this section.

Research suggests that parent's discussions with school staff regarding their child's wellbeing and progress can be a major prompt in getting help for themselves (Mentally Healthy Schools, 2019). Some of those interviewed for the current research felt their school were able to provide a wide variety of support for parents, from providing counselling services and support groups to supporting them in relation to their finances and parenting approaches. Some SENCOs highlighted the fine balance to be achieved in supporting parents

whilst also promoting their independence, and all the while keeping the child's needs as the primary focus.

6.4.3 Barriers to support in schools / difficulties arising

This section is relevant to research question 10: What are the barriers to supporting COPMHN in schools? A number of barriers and difficulties were noted in relation to the implementation of support for vulnerable groups in schools. These included: the academic/emotional wellbeing balance, engaging with vulnerable families, supporting vulnerable families and a lack of resources/funding.

All SENCOs interviewed referred to the conflicting priorities of the national curriculum and emotional wellbeing/mental health initiatives. SENCOs suggested that due to these conflicting agendas and time pressures, it was sometimes difficult to focus on emotional wellbeing and mental health agendas, when ultimately schools are judged on academic progress and attainment. Ofsted have recently confirmed additions to their inspection framework to include a focus on: building resilience, confidence and independence, and an increased focus on physical and mental health education (Ofsted, 2019). These additions promote opportunities for schools to be recognised for their additional support for vulnerable pupils. However, it is unclear how the changes will affect the overall judgement of a school, and what impact this will have on school practice.

Difficulties engaging with vulnerable families was highlighted as a major barrier by all SENCOs interviewed. SENCOs expressed that often vulnerable families will not identify themselves as vulnerable, meaning that they sometimes remain unidentified for a long time. SENCOs also discussed other vulnerable families who *have* been identified but are reluctant to engage in support offered by the school and external agencies.

Asking for support in relation to parenting can be difficult, as parents fear they might be judged as a bad parent or feel they might be at risk of having their children removed (Stallard, Norman, Huline-Dickens, Salter & Cribb, 2004). Bruland, Lenz and Wahl (2017) highlight self-stigmatising process for parents

with mental illness, whereby they feel responsible for their mental illness and its effects, which prevents them seeking help. There is likely to continue to be an issue with access and identification of vulnerable families, due to the stigma around mental health needs previously discussed, and the difficulties these families might have in initiating the kinds of discussions that might lead to appropriate support. The Department of Health (2015) highlight that COPMHN and their families may find it particularly difficult to access support services available to them as they may have a lifestyle that is not conducive to meeting regular appointments, and they may find support services alienating.

SENCOs reported that it can take a while for school staff to recognise the extent of a parent's mental health needs, meaning there can sometimes be a delay in a child being identified as vulnerable, and support being offered. SENCOs highlighted 'trust issues' with adults experiencing mental health needs and therefore recognised the importance of building relationships with these families. In some cases, SENCOs felt parents misunderstood the impact of their own difficulties on their child, often leading them to believe their child had inherent difficulties of their own. If there is an incomplete understanding of a child's situation and circumstances, there is a danger that parental beliefs about a child's difficulties may lead children to be assessed for and diagnosed with particular disorders. This has been highlighted in research, whereby failure to share information across professional groups has previously resulted in assessments of the child without acknowledgement of their parent's mental health problems (NSPCC, 2015). It is however important to recognise the increased risk that COPMHN have of developing needs of their own (Reupert, Maybery & Kowalenko, 2012), hence it can be difficult to unpick a child's needs and parent's difficulties. It is therefore important to recognise children's susceptibility to such difficulties when they are living with parental mental illness in order to intervene and provide preventative support for the whole family system at the earliest opportunity (Smith, 2004).

SENCOs commented that engaging with vulnerable families can also be difficult due to parenting issues that are sometimes observed where a parent has mental health needs. As the literature highlights, parenting behaviours can be significantly affected by mental illness, as can the general home environment (Bronte-Tinkew, Moore, Matthews & Carrano, 2007; Oyserman, Bybee,

Mowbray & Hart-Johnson, 2005; Pape & Collins, 2011; Rutter & Quinton, 1984; Van Loon et al., 2014). As a result of parenting difficulties, some SENCOs felt that it was difficult to put in place consistent and predictable support for the child across the home and school environments. SENCOs felt that although they could support parents to some degree in relation to their parenting difficulties, there were some things that school staff did not feel was their responsibility. This was either due to the feeling that they do not have the skills, expertise or power to deal with a particular situation, or that they felt that over-supporting parents in relation to basic parenting skills was perpetuating the problem and was not helpful in the long-term. Those interviewed reported difficulties in a maintained focus on the child's best interests, if school-based staff are responsible for supporting the needs of the entire family. Some SENCOs felt that there was a danger of school-based staff becoming so concerned with supporting the parents that the child's needs become less of a focus.

In relation to identifying and providing support for vulnerable families, SENCOs felt that health services should play more of a role. Those interviewed all reported a lack of involvement from health-based services at times, most notably; adult mental health services, children's mental health services and social care. SENCOs felt that the impact of this lack of collaboration resulted in disjointed support, an incomplete understanding of a child/family's situation and safeguarding concerns, as has been highlighted in the literature (Ofsted, 2013; Rouf, 2014). Allen (2011) posits that some children are 'failed' by services that do not intervene until problems reach a threshold at which they become a 'case' for child mental health services and recognises that at this stage, difficulties are more likely to have become entrenched. Such late intervention can be costly and often fails to achieve positive outcomes (Jopling & Vincent, 2016).

A lack of resources and funding was highlighted as an issue by all SENCOs and continues to be a pressure on education services in the UK (Andrews & Lawrence, 2018), hence this will need to be a consideration in the planning and implementation of support for vulnerable groups.

6.4.4 Future support for children of parents with mental health needs

This section is relevant to research question 9: How do school staff feel support for COPMHN could be implemented in schools? SENCOs interviewed made reference to a number of important considerations in relation to future support in schools. These included: early identification and prevention opportunities, increased education and awareness regarding mental health, staff training and support, closer links with health services and an improvement in home-school links.

Recent guidance produced by the Department for Education outlines a range of adverse parental, familial and contextual circumstances known to be risk factors for mental health problems (DfE, 2018). The guidance talks about prevention, whereby a safe and calm school environment that teaches children about mental wellbeing through the curriculum and school ethos and equips children with the skills to be resilient, reduces the likelihood of mental health problems. Evidence suggests that intervention is beneficial for children in difficult circumstances and is most effective when it occurs as soon as problems arise (Vincent, 2015). There is a positive association between early intervention and better outcomes for vulnerable children and young people (Blewett, Noble & Tunstill, 2010). The importance of identifying vulnerable children at the earliest opportunity was emphasised as a priority by those interviewed. SENCOs were eager to understand how best to encourage children to share their experiences and open up about difficulties faced at home. Difficulties arise when COPMHN are unaware that their experiences are different to anyone else's, and hence do not identify their situation as difficult/abnormal. In raising the profile of mental illness in schools, SENCOs felt that COPMHN may begin to recognise some of their experiences in relation to the topics discussed, allowing insight and understanding. Some SENCOs highlighted the importance of providing children with the correct language and vocabulary to talk about what is and is not okay for children to experience. They also mentioned the importance of empowering school-based staff to be able to have these conversations that might then lead to early identification.

All SENCOs felt that primary schools generally tend to focus on positive mental health and wellbeing but felt they did have capacity to teach children about mental illness. Some SENCOs questioned what kind of information might be

age-appropriate. I recognise that concerns around 'age appropriateness' surface in relation to topics that adults themselves feel uncomfortable discussing. However, myths, confusion and misunderstanding about mental illnesses can cause anxiety, strengthen stereotypes and lead to stigma (American Academy of Child and Adolescent Psychiatry, 2017). I would therefore argue that it is important that the topic of mental illness is discussed with children at the earliest opportunity, in a sensitive way. For children experiencing parental mental illness this is even more important, as increased understanding in relation to one's own situation can increase understanding and acceptance, promoting resilience (Reupert & Maybery 2009). When COPMHN gain cognitive and emotional understanding of the nature of their parent's mental health needs, this can result in alleviation of self-blame, increased understanding and improved resilience (Hinshaw, 2018).

SENCOs interviewed generally felt there were some very skilled and experienced staff in their schools who were able to support vulnerable children and families. This finding is in contrast to research previously discussed which suggests that school-based professionals lack understanding of the needs of COPMHN and how to support them (Bibou-Nakou, 2003; Bruland et al., 2017). However, the majority of those interviewed made comments to suggest that some school-based professionals such as teaching assistants and mealtime assistants were often asked to fulfil roles and responsibilities that they were not trained or confident to fulfil, and hence highlighted a need for further support from external agencies and professionals for these members of staff.

All SENCOs felt it was important to have ongoing professional development opportunities regardless of skill level and expertise within the school. In particular, some SENCOs mentioned the importance of practical advice and support for staff. As discussed, guidance from the DfE (2018) discusses the responsibilities of school-based staff to identify, intervene and signpost appropriately in relation to mental health needs. It is therefore important that there is a recognition of the current skill level within schools across staff roles, ensuring that necessary training and support is consistent both within and across schools and that this training and support is ongoing.

SENCOs felt that better links with health services would improve the support available and highlighted that schools can only offer so much. SENCOs hoped

for better links to social care, adult mental health services and CAMHS in particular. Improved communication and collaboration between education, health and care services has been an ongoing priority for safeguarding reasons (Rouf, 2014; SCIE, 2009), although it does not yet seem to be a reality. Such collaboration is vital for vulnerable children and their families to receive preventative and early intervention work from a range of appropriate professionals (Viganò et al., 2017; Falkov, 2012), as opposed to reactive support when their own difficulties meet a threshold.

As highlighted, schools are in a position to monitor children and families over time and recognise subtle changes in behaviour (Jopling & Vincent, 2016). In this way, school staff may identify parental mental health needs before the parent has accessed any mental health support services. However, there is another population of parents with mental health needs that do access support via adult mental health services but have not made their child's school aware of their needs as parents. Within this population of parents, if their children are not displaying any obvious behaviours in school, these vulnerable families could go undetected and unsupported. As highlighted in the literature, there is sometimes a lack of consideration in adult mental health services regarding the 'parent' status of clients (Maybery & Reupert, 2009). The NSPCC (2015) has highlighted the importance of professionals from adult mental health ensuring relevant information about parental mental health is shared with professionals involved in supporting any children in the family. There is also the suggestion that GPs should explore and take note of a patient's family circumstances in order to highlight any risk to children in the family (NSPCC, 2015). This suggestion was mirrored in the current research findings.

Increased collaboration between education, health and care services as well as a more holistic focus on those affected by a parent's mental illness is likely to increase identification and the effectiveness of support. SENCos reported that there are aspects of support required by parents and children in schools that school staff simply cannot provide, such as psychological support or intervention in relation to safeguarding concerns. SENCos highlighted that although they often identified safeguarding concerns and recorded and reported these in line with safeguarding policies and procedures, they were not always

satisfied that these were escalated to the correct level. Some SENCOs felt they were then 'holding' this information that they felt powerless to deal with.

SENCOs expressed frustration and concern in relation to their experiences of 'proving' that the mental health needs of a parent were impacting significantly on their child. Literature suggests that COPMHN are more likely to be missed, due to the often 'invisible' nature of mental illness (Gray et al., 2008). SENCOs often felt safeguarding issues in relation to parental mental illness can be much harder to comprehend for social care professionals than other circumstances that warrant social care involvement such as substance misuse and domestic abuse, despite the impact of these being similar, and the three often cooccurring (Cleaver et al., 2011).

The importance of understanding a child as being part of a complex set of relationships and systems has long been accepted in the field of psychology (Bronfenbrenner, 1979; Epstein, 1995, 2010). Throughout the interviews, SENCOs often commented on promoting home-school links and the importance of building relationships with parents in order to open avenues for communication, which they felt often led to a better understanding of a child's situation. This research has suggested that parent support advisers/parent liaisons have shown to play a valuable role in promoting partnership between home and school systems by engaging in relational work with families. Howland, Anderson, Smiley & Abbott (2006) highlight the importance of such relational work with regard to building positive relationships and trust and promoting avenues for effective communication. The importance of signposting to relevant external services and supporting parents to access these was also highlighted as important by the current research.

6.5 Phase 2b summary

The findings from phase 2b of my research highlights that the primary school SENCos interviewed appear to have a good understanding of the needs of children experiencing parental mental illness. SENCos could recognise how a mental illness might affect a parent's capacity to parent, how mental illness in the home might affect the environment for a child, and how this might impact on the child and their needs. SENCos highlighted a wide range of support available to children and their families in primary schools based on specialist staff knowledge and skills, whole school approaches and individualised support provision. As a result of these findings, it appears that schools are well placed to provide support to children and families where a parent has a mental illness. However, a number of barriers to support were noted. These included; difficulties prioritising support for emotional wellbeing due to attainment and progress pressures, difficulties engaging with and supporting vulnerable families and a lack of resources and funding. With regard to future support, SENCos highlighted the importance of increased education about mental health needs for children from a young age, early identification of vulnerable children and families, additional and ongoing staff training and support, better links with health care services and effective home-school relationships.

Chapter 7: Overall discussion and conclusions

7.1 Review of the findings

Phase 1 of this research highlighted the success of the Kidstime workshops in Southbridge Local Authority in relation to the aims set out by the Our Time Foundation (2019). Families and facilitators interviewed perceived a positive impact of the intervention in a number of areas; understanding and communication regarding mental illness, improved social connectedness and reduced isolation, improvements in mental health and improvements in family relationships and functioning. The school-linked referral system in Southbridge was also positively received, with interviewees recognising schools as well placed to identify vulnerable families and emphasising the value of collaboration and communication between Kidstime professionals and school-based staff. Despite the positive response to the intervention, there were barriers to support noted by the Kidstime families and facilitators. Interviewees also highlighted the need for the support provision and opportunities offered at Kidstime to be available more frequently, and to be more accessible for families.

Phase 2a sought to explore the views of secondary-school pupils experiencing parental mental health needs in relation to their perceived needs as COPMHN and the support they had received within school. These children noted additional responsibilities, a negative impact on their own mental health and an increased need for additional respite from their responsibilities. These children also expressed the need to present themselves as strong and capable. These children shared some positive experiences of support, as well as experiences of feeling misunderstood and unsupported at times. They also expressed the need to escape to a safe place when things become overwhelming in school. Children in phase 2a also discussed the importance of those supporting them having a genuine understanding and respect for their situation. A key theme arising within this group was a lack of trust for others based on their personal experiences, highlighting this group as difficult to engage in support. These children felt it was important for schools to make attempts to reduce the stigma associated with additional needs generally, as this was also a barrier to accessing support. They felt that increased education would promote understanding which might help with regard to this stigma.

Findings from phase 2b highlight school-based staff as well placed to support

the needs of COPMHN due to their access to children, knowledge and skills and capacity for support. Barriers to the implementation of support included: difficulties prioritising support for emotional wellbeing due to additional school-based pressures, difficulties engaging with and supporting vulnerable families and a lack of resources and funding. With regard to future support, SENCOs highlighted the importance of: increased identification of vulnerable families, increased education about mental health needs, closer working with health services and the promotion of home-school partnerships.

7.2 Key contributions of the current research

The BPS (2018) posit that all provision relevant to mental health should be co-produced alongside children, young people, families and communities. They suggest that these groups should not be seen as the problems to be ‘fixed’, but instead their views should be considered in relation to solutions. The overall aim of this research was to promote a better understanding of the support needs of COPMHN and their families by exploring their views and experiences, as well as the views and experiences of those involved in their support.

The following section brings together findings from both phases of the current study to highlight contributions to knowledge and understanding. As per the overall aim of the study, I will now outline the reported needs of COPMHN and their families and the types of support that COPMHN have highlighted as effective. I will then discuss how such aspects might inform school-based support provision, incorporating the findings from this research that relate to future support aspirations. Barriers to overcome in relation to the implementation of support will also be discussed throughout. I will then highlight implications for policy, EPs and EP services. I will also highlight the limitations of this research and possible future research directions.

7.2.1 Contributions to understanding the needs of children experiencing parental mental health needs

The broad needs of COPMHN were not a key focus of this research, as these needs are already well documented (Cooklin, 2006), however those interviewed

reflected on their needs in relation to effective and ineffective support. Kidstime facilitators, parents and SENCos identified the sometimes unpredictable, chaotic and onerous lives of children living with parental mental illness. These interviewees also noted social, emotional and mental health difficulties that COPMHN often experience and the importance of safeguarding considerations. Children themselves reflected on the additional responsibilities that they take on that can often impact their learning opportunities and social lives. They also highlighted difficulties understanding their parent's behaviours and knowing how best to support them. The above findings resemble other research that has sought to explore the needs of COPMHN (Cooklin, 2010; Reupert et al., 2012).

Those who considered themselves to be young carers for family members with mental illness highlighted their difficulty in accessing any form of support outside of school hours, due to their caring responsibilities, which has implications for support. These children noted negative consequences on their education and social opportunities. Findings from the phase 1 interviews with Kidstime families and phase 2a focus groups with secondary school COPMHN highlighted the importance of opportunities to be free from the strains of family life to engage in enjoyable activities that give children the opportunity to be children rather than carers. Therefore, this need to escape the realities of parental mental illness for short periods is considered to be important across populations interviewed and could be considered in relation to future support.

Children of both primary and secondary age referred to their own mental health needs, although the young people themselves did not always link these needs to their position as a COPMHN/young carer. It is important to recognise that these 'problems' that the children express they have may be due to the internalisation of a narrative they have heard throughout their lives. Linking findings from phase 1 and 2a, where a number of parents and children identified children's mental health needs, it is possible that COPMHN lack understanding about how their own mental health and the mental health of their parents are linked. Children's risk of negative effects relating to their circumstances as a COPMHN can be mediated via appropriate intervention (Falkov & Lindsey, 2002). Cooklin (2013) suggests that children need to be supported to achieve distance from the parent's emotional life and behaviour so as they can recognise their mind as distinct from their parents. Research has

suggested that a clear understanding one's own situation and a recognition of the impact of the adverse experiences they have had, can help children to be more resilient (Rutter 1999; Dyregrov, 2001, 2010). This highlights the need for COPMHN to be identified, educated and supported via early intervention, as is reflected in the current research findings.

Research findings from the current study suggest that those experiencing parental mental illness might demonstrate a need to present themselves as strong and capable and have difficulty trusting others. This finding suggests that this group may be hard to engage in support, with a likely distrust of professionals. Aldridge and Stuart (1998) recognised the tendency for COPMHN to display 'false maturity', which may underpin the secondary school pupils' desire to present as strong and capable. This 'false maturity' and the need to present as strong and capable may lead to a misperception by others that these pupils are not vulnerable and can look after themselves, meaning they might not be identified as in need of support.

7.2.2 Considerations in planning support for children of parents with mental health needs

7.2.2.1 School-based support

Due to the current strain on mental health services, concerns have been raised in relation to children who may require access to specialist support services (Allen & Hardy, 2013). COPMHN attending primary school may not present with externalising behaviours, despite the fact that they may be in need of support. Even when children do present with social, emotional and mental health needs, they do not always reach the threshold for support from CAMHS. If the needs of these children are significant enough to reach the threshold, the long waiting lists mean a delay in support (CQC, 2017). It is therefore important to consider other means by which these children can be identified and supported. In particular, it is important to recognise opportunities for early intervention, whereby the emerging needs of children are supported as soon as they are identified and can be supported appropriately, before they become a case for CAMHS.

The green paper 'Transforming Children and Young People's Mental Health in Schools' (2017) suggests that the school environment is well suited to a graduated approach to children's mental health, in which children at risk can be identified and supported. The paper also suggests that the school environment is non-stigmatising, whereby interventions within this context are more acceptable to children and their families. The current research was particularly concerned with the capacity of schools to provide support for COPMHN. This research has highlighted schools as an appropriate setting to identify children in need of support, due to the contact school staff have with children on a regular basis (Jopling & Vincent, 2016).

Schools have also been highlighted as well placed to link in with other support services who may be supporting the family. For some of the families attending the Kidstime workshops, they were not currently involved with mental health support services and hadn't been for some time. Therefore, if Kidstime did not operate via a school-linked referral system in Southbridge, the families currently in attendance would not necessarily be aware of it. This highlights that schools may provide identification and insight in relation to the needs of a population of children in need that would not otherwise be identified.

There were mixed thoughts as to whether or not parents felt staff at their child's school understood their family's needs. For those that did feel staff understood, this was highly valued, with school-based support being considered a vital part of the overall support for the family. Children in secondary schools were less positive about receiving support in school, but this was often due to the stigma around accessing such support.

The school staff interviewed for this research presented as very knowledgeable about COPMHN, often outlining a range of appropriate support to meet their needs and in some cases, the additional needs of the extended family. SENCos commented on training in and awareness of ACEs and trauma-informed approaches that they felt provided a foundation for a whole-school approach to identifying and supporting vulnerable children. Such whole-school approaches are advocated by the DfE (2018). It is important to consider however that the school staff interviewed may well be a well-informed and experienced minority. I will discuss this shortly in relation to research limitations.

Overall, based on the findings from this research I would suggest that schools are well-positioned to meet the needs of COPMHN. However, I would add that in order to do so effectively, school staff will need to receive extra training, and ongoing supervision, support and funding as highlighted by the current research findings. Knowledge of successful elements of interventions such as Kidstime, as well as the views of the COPMHN themselves in relation to their needs and perceptions of effective support should be used to inform future support in schools.

7.2.2.2 Education

The importance of COPMHN understanding their parent's mental health needs and associated behaviours has been highlighted as important for a variety of reasons that have previously been discussed (Cooklin, 2010). Grove et al., (2013) suggest that when people become aware of and informed about a personally relevant subject of which they were previously ignorant, they are better able to improve their circumstances. Beardslee and Poderefsky (1988) have suggested that an accurate understanding of one's own circumstances can impede the transmission of mental illness in families. It has also been suggested that an increased knowledge and understanding regarding a parent's mental illness can promote the child's use of effective coping strategies (Cogan, 2004). An increased understanding of a parent's mental illness has also been linked with an increase in the child's resilience, increased empathy for their parent and improved communication between parent and child (Grove et al, 2013; Wolpert et al., 2015).

The current research extends previous research with COPMHN to suggest that *all* children may require a better understanding and increased acceptance of mental health problems. This research highlighted that where schools do educate children about mental health, it is often with a predominant focus on the promotion of positive mental health and wellbeing. The need to teach children from a young age that "it's okay not to be okay", was highlighted as important in the current research, specifically for the young carers who often felt that they must present as strong and capable in order to fulfil their role as a carer for their family member.

This research has highlighted that children and their families are not always forthcoming in talking openly about their difficulties with those who can help, possibly fearing judgement as well as other negative consequences that have previously been discussed (The Children's Society, 2008a). The current research has highlighted that children in schools continue to experience the stigma associated with having additional needs, emphasising that this is often due to a lack of understanding and awareness from others regarding their often-difficult circumstances. Findings have also highlighted that parents themselves may be in need of education around vulnerable groups, with the suggestion that this could be done via a 'bottom-up' approach, with children receiving education in their early schooling, with awareness and knowledge filtering up to parents.

Parents with mental health needs may also require sensitive support to understand the impact that their mental health needs might have on their children, as it has been suggested that this leads to better outcomes for the child (Beardslee et al., 1998). This research has highlighted that for some parents, they either don't acknowledge they have a mental health need, or they don't recognise the impact of their mental health needs on their children. These findings are also mirrored in previous studies (Thomas & Kalucy, 2003). In some situations, parents have approached school-based staff and support services to highlight a difficulty that their child is experiencing, without recognising how their own mental health needs might be contributing to this difficulty. Parents with mental health needs may actually have distorted views of their children, whereby they believe a child is to blame for their mental health needs, or that a child has behavioural problems when there is no evidence for this (Cleaver et al., 2011; Hogg, 2013). Mackereth, Göpfert, Harrison and Mahoney (1999) posit that when children do not receive an appropriate explanation about their parent's mental illness, they can experience feelings of blame and responsibility. It is therefore important that parents can discuss their mental illness with their children and appreciate the impact that this might have on their child's behaviour. Parent's distorted beliefs could lead to inaccurate narratives about a 'difficult' child with 'problems', which the child may internalise. These distorted beliefs could eventually lead to a diagnosis for the child, if the family context is not accurately explored or understood by those supporting and assessing the child (NSPCC, 2015).

Parents are likely to require support to explore and understand the links between their mental health needs, but this needs to be done in a sensitive way. It is important that parents do not feel patronised, stigmatised and blamed for their child's difficulties (Weare, 2015), as this could lead to disengagement with school staff and in relation to support interventions. Conversations that require parents to acknowledge how their mental health needs might be affecting their children are likely to be difficult, as this research has highlighted. It might be difficult for school-based staff to approach such discussions in such a way so as not to appear blaming. A strength-based or solution focussed approach might support parents to engage in support (Weare, 2015).

This research reinforces the importance of COPMHN being identified early and receiving support and education regarding their situation. This research also emphasises the need for further education on mental illness for all children, and their families. Whole school approaches to mental health education and support were particularly valued and deemed to be most successful.

7.2.2.3 Family-focused support

Research by Tienari et al., (2004, 2006) and Rutter (2003), demonstrated that when relationships in the child's environment are improved, the child's future resilience to mental illnesses is enhanced, even when there is prior history of mental illness in previous generations. A wealth of research highlights the benefits of a family approach to supporting mental health needs in families (Apter et al., 2017; Fadden & Heelis, 2011; Falloon, 2003; Thanhäuser et al., 2017). The findings from the current research further support the success of family focused interventions for COPMHN such as Kidstime, highlighting a range of positive impacts on the children and parents in attendance.

School staff interviewed for the current research also recognised the importance of involving families in support for the child, especially where the parent has a mental health need. School staff often commented on the value of their parent support and family liaison staff, emphasising the importance of a key person who can reach out to families that may be in need to build relationships, gain their trust and build their confidence to engage in support. These staff are in a position to open avenues for communication with families, leading to an

increased understanding of the needs of vulnerable families, leading to more effective identification and support for children in school.

7.2.2.4 Promoting links with health and care services

I would suggest that education provisions have a key role to play in supporting COPMHN, for the various reasons I have previously discussed. It is my suggestion, based on the findings of the current research, that schools can be involved in identifying and supporting children at an early intervention level. However, findings from this research suggest that despite feeling confident to identify COPMHN, there is still a desperate need for more involvement from other specialist services such as those mentioned previously, to advise and support schools in relation to the needs of this vulnerable group.

This research has highlighted a continued lack of communication and collaboration between education, health and care that has previously been highlighted (Cooklin 2010; Foster, O'Brien & Korhonen, 2012; Katz & Hetherington, 2006). It has been argued that children and young people experiencing parental mental illness fall between the obvious responsibilities of all the relevant professionals (Cooklin, 2010). Cooklin (2010) argues that mental health, social care services and CAMHS should be jointly responsible for this group of children yet acknowledges that some of these professionals may be ill-equipped to support this group due to time pressures or a lack of experience and expertise. The author also emphasises that social care services are often hard-pressed to respond to the most severe and obvious cases of child abuse, and highlights that the vulnerable nature of COPMHN is not always obvious. This was also highlighted as a concern by the SENCOs in the current research. COPMHN themselves can often hide fears and concerns due to loyalty to their parents and fear of being removed from the family (Cooklin, 2010).

A recent BBC panorama documentary 'Kids in Crisis' highlighted that families in need often have to wait far too long for the support they need from CAMHS, due to the services being overstretched and under-resourced (Young Minds, 2018a). This highlights that there may not be capacity currently for CAMHS to link in with schools due to high caseloads. However, I would argue that putting in preventative support at an early level will reduce the numbers of children

eventually reaching the threshold for CAMHS support in the future. A long wait for treatment and the thresholds that are required to be met means that children and young people struggle to access support unless they reach a crisis point at which their problems are often complex (Young Minds, 2018a). It is also important to note that only 8.7% of the total mental health budget in England goes on support for under-18s, which might suggest that the overwhelming majority of funding for mental health is used in reactive support (Young Minds, 2018b).

It seems as though specialist mental health support services are currently stuck in a continuous cycle whereby, they are attempting to respond to the need that reaches threshold, meanwhile, for the children who do not meet threshold, their difficulties escalate until a point at which they are deemed to require support. The views of the BPS (2018) reflect this, suggesting that if more emphasis were placed on preventative measures, the later demand on specialist services would reduce. Recent publications 'Transforming Children and Young People's Mental Health' (Department of Health and Social Care & DfE, 2017) and 'Future in Mind' (Department of Health, 2019) recognise 'at risk' groups and the importance of preventative measures, however the primary focus of these proposals continues to be on reactive, rather than proactive support. The narrow focus of the proposed government initiatives does not take account of many vulnerable groups and puts significant pressure on the school-based workforce without ensuring sufficient knowledge, expertise and resources (House of Commons Education and Health and Social Care Committees, 2018).

Findings from the current research also recognise the perception that there is more that GPs and adult mental health services could do regarding the sharing of information when there is a parent with mental illness. Baulderstone, Morgan and Fudge (2013) add weight to this finding, suggesting that GPs can use their skills to communicate with parents about the possible implications of mental illness on their functioning within the family. GPs can also refer in to educational supports where they exist.

The current research has also highlighted that school staff are often concerned when there are safeguarding issues that are deemed to fall just below the threshold of social care involvement. In such scenarios, school staff are unsure as to how to support the child and the wider family. School staff often felt the

impact of a parents mental illness on their child was underestimated by social care services, as has been noted in previous research (Cleaver et al., 2011; Gray et al., 2008) This demonstrates the need for stronger links between social care services and schools in order to recognise and respond to safeguarding issues where a parent has a mental illness. Considering the high prevalence of parental mental illness as a factor in serious case reviews (Sidebotham et al., 2016), this is an urgent priority.

The above discussion highlights the need for an overall improvement in communication between education, health and care services. Despite the strain on the majority of public services including education (Belfield et al., 2018), I would argue that all of the aforementioned services are in a position to identify specific subsections of the COPMHN population. Therefore, more effective collaboration and communication between these services as well as assessment processes that consider the wider family of an individual 'client' would allow as many vulnerable children as possible to be identified and appropriately supported and protected.

7.3 Originality and contribution to knowledge

The current research offers an original contribution to knowledge in that it recognises and evaluates support available to a vulnerable subsection of COPMHN who are not easily identified or supported currently.

Previous research by Wolpert et al., (2014) evaluated the benefits and limitations of the Kidstime workshops as they operate via health-based referral and delivery systems. This research sought to explore the mechanisms by which Kidstime has a positive impact on the families attend, and an enhanced focus on the referral process in Southbridge.

Kidstime in Southbridge provides the opportunity for COPMHN to be recognised and supported, even if they, or their parents, are not currently known to other support services. In some situations, Kidstime is their first and only experience of support in relation to parental mental illness. This piece of research is the first to explore the school-linked referral context of the Kidstime intervention, and to seek the perspectives of the facilitators supporting it. This evaluation of the Kidstime intervention in Southbridge suggests positive outcomes for families

that attend Kidstime. However, such families in other areas of the country would not necessarily be identified or have the opportunity to be supported in the same way. In other Kidstime workshops across the country, it can be argued that children and families already have some form of support in place before accessing Kidstime, as they are often known to health or social care support services. This research highlights the unique positioning of schools to be able to identify and support children experiencing parental mental health needs, particularly if these children are currently unsupported due to not reaching a threshold for support for themselves, or their parents not yet accepting their own mental health difficulties.

This research is also the first to seek the views of COPMHN themselves in relation to the support that they have experienced in school and is the first to provide these children with the opportunity to give their views regarding future support. This research has highlighted the important position of schools in identifying vulnerable children in need of support and providing support in collaboration with appropriate support services. Findings from this research reflect some good practice already in place in primary schools to support COPMHN and other vulnerable groups. There is therefore an opportunity for aspects of good practice to be shared and embedded across educational settings.

7.4 Significance and implications of the research

7.4.1 Significance and implications for policy

The current research has implications for educational and multi-professional policies. As discussed above, the current emphasis on supporting children in schools is oriented more to reactive than proactive approaches. I would argue that processes and policies need to be in place to promote a focus on groups known to be at risk of developing mental health needs, as discussed above.

Regarding policies relevant to various professional groups, this research has added weight to the vast research that suggests an urgent need for better communication and collaboration between professional groups responsible for supporting individuals that are part of a wider system. I would argue, based on the findings from this research, that there needs to be improvement in the

collection and sharing of data regarding 'at risk' groups so that risks can be assessed and monitored. I believe that there is a need for policies that specify the collection of data regarding a parent's familial circumstances when they access adult mental health support services as well as the collection of data regarding a child's home and family circumstances when undergoing an initial CAMHS assessment. I believe that such processes are likely to result in more vulnerable children being identified and supported appropriately at an earlier stage.

7.4.2 Significance and implications for educational psychology practice and educational psychology services.

7.4.2.1 Mediating psychological processes

It has been suggested that psychological processes mediate the risk of developing mental ill health (Kinderman et al., 2013). As children experience the symptoms of their parent's mental health needs, they conceptualise their observations and experiences in particular ways (Slominski, 2010). Slominski (2010) discussed that the psychological processes determining the way in which children think about and deal with their experiences affects emotional responses and coping strategies, which mediate the impact of their parent's mental illness on their own wellbeing. Theories of stress and coping add support to this idea, suggesting that one's interpretation of a stressful situation mediates the association between the degree of stress and the impact of the stressor on the individual (Compas, Connor-Smith, Saltzman, Thomsen & Wadsworth, 2001).

If psychological processes can mediate risk, it is important to consider that psychological support might be an appropriate intervention for those experiencing parental mental illness. Assessing a child's perception and understanding of their parent's mental health problems and discussing capacity to cope with their situation may help professionals to know how these children and their families might best be supported.

7.4.2.2 Relevance to educational psychology practice

It could be argued that EPs are in a position to offer support in relation to the psychological processes that mediate risk of future mental health problems.

EPs often have scope to work at the systems, group and individual levels with regard to support and intervention (Curran, Gersch & Wolfendale, 2003). An EP's position allows a 'strategic vantage point' from which they can consider the wide range of influences on an individual to understand how this may affect them, through applying their knowledge of psychology (Fallon, Woods & Rooney, 2010). Findings from the current research may therefore support EPs to plan intervention and support for COPMHN and their families at the systems, group and individual level.

At the systems level, EPs might be able to influence policy and practice in relation to the identification of COPMHN and the support available to them and their families. This could be done via their roles in strategy groups relevant to the topic of mental health and wellbeing. EPs might also be able to offer training at a whole-school level for staff in relation to the needs of COPMHN or could offer supervision for staff responsible for supporting these children in schools. EPs may also be able to offer some individual work with the child and their family members. Farrell et al., (2006) suggested EPs are well placed to build "bridges between school and community". It could therefore be argued that where a parent has a mental illness, EPs may have a role in facilitating the home-school relationships, supporting families and school staff to solve problems and supporting the link to external support services within the community.

In relation to the previous discussion regarding the evident misattribution of a child's difficulties in some circumstances, EPs are well placed to support schools and families to explore the factors that may impact on a child's ability to function in school, opening up avenues of communication regarding the family circumstances where appropriate. Such conversations could be challenging to initiate and facilitate, however an EP's skills and training to deal with such situations, and their solution focused approaches (Stobie, Boyle & Woolfson, 2005) mean they are well placed to negotiate such discussions alongside the family and school staff who know the child best.

The government proposed 'Mental Health First Aid' initiative proposes the education of school-based staff regarding how to identify and support children experiencing mental health problems. However, the BPS (2018) highlight that in dealing with mental health of children and young people, training alone is not

enough and suggest that ongoing supervision and consultation is essential. The Mental Health First Aid initiative assumes that one person will take the lead on raising the profile, knowledge and understanding of children's mental health needs. This is an enormous burden on a single person and assumes pre-established knowledge of child development (BPS, 2018b). This is an area in which EPs may be able to offer support, for example in the form of refresher training, supervision or consultation. EPs are often already linked to schools and do have the prerequisite knowledge about child development and skills in applied psychology (Cameron, 2006).

School constructs regarding the EP role are a commonly reported barrier for EPs to work in the area of children and young people's mental health (Atkinson, Squires, Bragg, Muscutt & Wasilewski, 2014; Price, 2017). The current research also highlighted that there may be misunderstanding from parents about the role that schools can take in supporting the mental health and wellbeing needs of children. There is therefore an opportunity for EPs to inform their schools about their potential role in supporting the mental health and wellbeing of children and young people. It is also important that parents of school-aged children are made aware of the ways in which schools can offer support both internally and via their links to external support services, for example CAMHS.

The BPS (2018) present some possible ways forward in addressing the gaps in support available to vulnerable groups of children at risk of mental health needs, utilising the skills and experience of educational psychologists. They discuss the need to reinstate educational psychology early-intervention services, allowing assessment and support for children in need. They also suggest the need for applied psychologists to be working more directly in schools, allowing them to guide and support both proactive and reactive responses to need. The BPS (2018) also advocate the development of policy relating to the recognition of ACEs, in order to promote and maintain positive mental health and wellbeing, with a particular focus on 'at risk' groups.

7.4.2.3 Implications for educational psychology services

This research highlights the unique set up of the multi-agency support team in Southbridge as conducive to early help and preventative support. As discussed, the multi-agency team in Southbridge is partially funded by the local authority in

terms of the statutory EP component of the service, but is further funded by school subscriptions for support from the multi-agency team. This model allows interventions such as Kidstime to be available to primary school-aged children and their families, who may not otherwise be able to access support due to thresholds.

Referrals to the multi-agency team are reviewed by experienced professionals who are skilled at identifying wider systemic issues that may be contributing to or perpetuating difficulties for children in schools. Having the educational psychology service as part of this team allows for more holistic support, and preventative practice, as has been highlighted in previous research (Gaskell & Leadbetter, 2009).

7.5 Strengths and limitations of the current research

This research has focused on the support needs and experiences of COPMHN, and the capacity of school-based staff to support these needs. There has been little research from an educational perspective in this area to date, and therefore the findings from the current research offer a valuable contribution to knowledge.

The current research findings are based on a small sample of parents, children, Kidstime facilitators and SENCoS from the Southbridge Local Authority and the surrounding area and hence should not be assumed to be generalisable outside of this population. The SENCoS interviewed for phase 2b often highlighted their school as more focused on mental health and wellbeing than other schools in their local area. These staff were often from schools within highly deprived areas of a city and therefore may have more experience identifying and supporting COPMHN, due to the link between deprivation and mental health problems (Fone et al., 2007). Also, as these particular members of staff were school SENCoS, it is important to consider that they are likely to be the most experienced within the school. It is therefore important to consider the extent to which the school SENCo's knowledge and understanding in relation to vulnerable groups is disseminated effectively throughout the school. I question whether the eagerness of the SENCoS to engage in the research was due to elevated levels of confidence and experience in relation to understanding and supporting this vulnerable group. I recognise that SENCoS knowing little about

the subject area were unlikely to want to expose this, or they may have felt they had little to offer to the research and hence the sample may not be representative of average school approaches. Nevertheless, the knowledge and experience of the SENCos interviewed gives a valuable insight in to the way in which vulnerable children might be effectively supported.

It was more difficult than anticipated to gain the views of the younger children attending the Kidstime workshops. Despite adapting the questions asked and providing visual prompts and the option for more creative tasks, I feel some children struggled to express themselves fully. If I were to do the research again, I might approach the data collection for this aspect of the study differently, with an even greater focus on the practical and creative methods of eliciting the views of the children.

Within the focus groups for phase 2a, there were some dominant characters in both groups, as is common with this method of data collection (Smithson, 2010). As a result, I feel that some of the group members didn't contribute as much as they could have done. However, when considering this in relation to the advantages of focus groups previously discussed, I would still consider this to have been an effective method of gathering the group's views.

7.6 Directions for future research

In relation to the Kidstime intervention, there is a need to further explore the health-based referral systems operating elsewhere in the country, in order to better understand the advantages and disadvantages of this system in comparison to the school-linked system in Southbridge. It might also be useful to conduct research in to the impact of Kidstime children and families once their attendance has ceased, to explore the longevity of the positive impacts highlighted in the research.

The majority of research studies regarding the needs of COPMHN and their families are often conducted on clinical populations, whereby the parent has a diagnosed mental health condition. A valuable direction for future research could therefore be to explore the needs of COPMHN in non-clinical populations, as it is this population that are likely to benefit most significantly from school-based identification and support.

It would also be useful to conduct further research on the support available to COPMHN and vulnerable children more widely in schools, as SENCOs interviewed for the current research highlighted the paucity of a focus on mental health and wellbeing practices in other surrounding schools. The current research also focused on SENCOs only in relation to school-based support. These professionals are likely to be the most aware, knowledgeable and experienced regarding the support needs of vulnerable groups within their schools. It may therefore be useful to explore the views and practices of other school-based staff, to ascertain whether aspects of good practice are disseminated throughout the school.

A number of SENCOs discussed the importance of whole school approaches to mental health and wellbeing practices; however, this is a relatively new area of focus for some schools, likely in response to the aforementioned government initiatives and heightened public awareness of this topic. It would therefore be useful to explore the nature of these whole-school approaches, if and when these become embedded more widely.

7.7 Concluding comments

COPMHN are a vulnerable group at risk of a range of negative experiences and outcomes relating to their situation (Reupert et al., 2012). To date there has been a lack of published research on the mechanisms by which support interventions for this group are impactful and the availability of school-based support. This research has illuminated aspects of effective support for COPMHN and their families and has contributed ideas for future support.

Findings from the current research have highlighted the mechanisms by which the family focused intervention 'Kidstime' has a positive impact on the families that attend. These findings support the need for an increased focus on early identification and intervention for groups known to be at risk, such as COPMHN. Most notably, this research has reinforced the potential value of school-based support services in identifying and supporting COPMHN. This research suggests that school staff are increasing in their knowledge, understanding and awareness of vulnerable groups and reinforces that the stable, structured environment of schools allows opportunities for regular monitoring of vulnerable

children. This supports the suggestion that schools are appropriately positioned to identify COPMHN and provide early intervention opportunities. Despite being well placed, the current findings highlight that school staff are likely to require initial and ongoing support to develop and maintain the appropriate understanding and skill set to support such vulnerable groups. There is also the need for good practice to be embedded and extended across educational settings. As well as this, the current research findings strengthen the argument for improved collaboration between education, health and care services regarding identification of and support for vulnerable children.

The findings from this research are relevant to COPMHN themselves, their families and those who support them. Educational psychologists might consider the findings from this research to advise and support schools in relation to the needs of COPMHN, empowering school staff to identify vulnerable groups and supporting the planning and implementation of appropriate intervention.

For me personally, this has been an incredibly interesting piece of research to complete and I am grateful to have learned so much from the participants and the process. This research has given me a greater insight in to the challenges for children and families where a parent has a mental illness, as well as some of the ways that this vulnerable group can be effectively supported. I am pleased to have been able to contribute to the research evidence regarding the support needs of COPMHN and aim to consider the findings to inform my own future practice as an educational psychologist.

Word Count: 41, 444

References

- Acri, M. C. & Hoagwood, K. E. (2014). Addressing Parental Mental Health Within Interventions for Children. *Research on Social Work Practice*, 25(5), 578-586. <https://dx.doi.org/10.1177%2F1049731514546027>
- Aldridge, J. (2006). The Experiences of Children Living with and Caring for Parents with Mental Illness. *Child Abuse Review*, 15, 79-88. <https://doi.org/10.1002/car.904>
- Aldridge, S., & Stuart, A. (1998). The Willow Scheme: an innovative project offering befriending support to young carers living with a severely mentally ill relative. *Presentation at National Children's Bureau Conference on 'Mentally ill parents and their children', London*, 111.
- Allen, A., & Hardy, J. (2013). The future of educational psychology. In C. Arnold & J. Hardy (Eds.), *British educational psychology the first hundred years* (pp. 141-149). Leicester: The British Psychological Society.
- Allen, G. (2011). Early intervention: The next steps. Retrieved from <https://www.gov.uk/government/publications/early-intervention-the-next-steps--2>
- American Academy of Child and Adolescent Psychiatry (2017). *Facts for Families: Talking to children about mental illness*. Retrieved from http://www.aacap.org/aacap/fffprint/article_print.aspx?dn=Talking-To-Kids-About-Mental-Illnesses-084
- Anant, S. S. (1966). The need to belong. *Canada's Mental Health*, 14, 21-27. [https://doi.org/10.1016/0001-6918\(67\)90035-2](https://doi.org/10.1016/0001-6918(67)90035-2)
- Andrews, J., & Lawrence, T. (2018). *School funding pressures in England*. Retrieved from https://dera.ioe.ac.uk/31289/1/School-funding-pressure_EPI.pdf
- Antonucci, T. C., & Israel, B. (1986). Veridicality of social support: A comparison of principal and network members' responses. *Journal of Consulting and Clinical Psychology*, 54(4), 432-431. <http://dx.doi.org/10.1037//0022-006X.54.4.432>
- Apter G., Bobin, A., Genet, M. C., Gratier, M., & Devouche, E. (2017). Update on Mental Health of Infants and Children of Parents Affected With Mental Health Issues. *Current psychiatry reports*, 19(10), 72. <http://dx.doi.org/10.1007/s11920-017-0820-8>.

- Ashton, R. & Roberts, E. (2006). What is Valuable and Unique about the Educational Psychologist? *Educational Psychology in Practice*, 22(2), 111-123.
<https://doi.org/10.1080/02667360600668204>
- Atkinson, C., Squires, G., Bragg, J., Muscutt, J., & Wasilewski, D. (2014). Facilitators and barriers to the provision of therapeutic interventions by school psychologists, *School Psychology International*, 35(4), 384 – 397.
<https://dx.doi.org/10.1177%2F0143034313485849>
- Baker, M. (2015). Future selves interventions: A critique of the current evidence base. *DECP Debate*, 154, 24-30. Retrieved from
<https://shop.bps.org.uk/publications/publication-by-series/decp-debate/decp-debate-154-march-2015.html>
- Baker, S., Farmer, P., & Winstanley, M. (2017). The importance of public awareness campaigns for mental health. Retrieved from <https://www.time-to-change.org.uk/news/importance-public-awareness-campaigns-mental-health>
- Banerjee, R., Weare, K., & Farr, W. (2014). Working with 'Social and Emotional Aspects of Learning' (SEAL): associations with school ethos, pupil social experiences, attendance, and attainment. *British Educational Research Journal*, 40, 718–742. <https://doi.org/10.1002/berj.3114>
- Barrett, P., & Turner, C. (2001). Prevention of anxiety symptoms in primary school children: Preliminary results from a universal school-based trial. *British Journal of Clinical Psychology*, 40, 399–410. <https://doi.org/10.1348/014466501163887>
- Baulderstone, M. J., Morgan, B. S., & Fudge, E. A. (2013). Supporting families of parents with mental illness in general practice. *The Medical journal of Australia*, 199(3), 11-13. <http://dx.doi.org/10.5694/mja11.11146>
- Beardslee, W. R., & Poderefsky, D. (1988). Resilient adolescents whose parents have serious affective and other psychiatric disorders: importance of self-understanding and relationships. *American Journal of Psychiatry*, 145, 63–69.
<http://dx.doi.org/10.1176/ajp.145.1.63>
- Beardslee, W. R., Swatling, S., Hoke, L., Rothberg, P. C., Velde, P. V. D., Focht, L., & Podorefsky, D. (1998). From cognitive information to shared meaning: Healing principles in prevention intervention, *Psychiatry*, 61(2), 112-129.
<http://dx.doi.org/10.1080/00332747.1998.11024822>

- Beardslee, W. R., Wright, E.J., Gladstone, T. R. G., & Forbes, P. (2007). Long-term effects from a randomized trial of two public health preventive interventions for parental depression, *Journal of Family Psychology*, 21, 703–713.
<http://dx.doi.org/10.1037/0893-3200.21.4.703>.
- Becker, S. (1995). *Young carers in Europe: an exploratory cross-national study in Britain, France, Sweden and Germany*. Retrieved from
<https://dspace.lboro.ac.uk/dspace-jspui/bitstream/2134/628/3/YoungCarersinEurope1.pdf>
- Belfield, C. Farquharson, C. & Sibieta, L. (2018). Annual Report on Education Spending in England. Institute for Fiscal Studies: London. Retrieved from
<https://www.ifs.org.uk/uploads/publications/comms/R150.pdf>
- Bibou-Nakou, I. (2003). Parental Mental Health/Illness and Children's Well-Being: Implications for the Educational Services. *International Journal of Mental Health Promotion*, 5(1), 6-15. <https://doi.org/10.1080/14623730.2003.9721891>
- Bibou-Nakou, I. (2004). Helping Teachers to Help Children Living with a Mentally Ill Parent: Teachers Perceptions on Identification and Policy Issues. *School Psychology International*, 25(1), 42-58.
<https://doi.org/10.1177%2F0143034304041502>
- Biederman, J., Petty, C., Faraone, S. V., Henin, A., Hirshfeld-Becker, D., Pollack, M. H., Figueiredo, S., Feeley, R., & Rosenbaum, J. F. (2006). Effects of parental anxiety disorders in children at high risk for panic disorder: A controlled study. *Journal of affective disorders*, 94(1), 191-197.
<https://doi.org/10.1016/j.jad.2006.04.012>
- Bilsborrow, S. (2004). What we want from adult psychiatrists and their colleagues: 'Telling it like it is'. In M. Göpfert, J. Webster & M. V. Seeman (Eds.), *Parental psychiatric disorder: Distressed parents and their families* (pp.3-8). Cambridge: Cambridge University Press. <https://doi.org/10.1017/CBO9780511543838.003>
- Blewett, J., Noble, J. & Tunstill, J. (2010). *Improving the safety, health and wellbeing of children through improving the physical and mental health of mothers, fathers and carers*. Retrieved from:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/182291/DFE-RR084.pdf

Bowers, H., Manion, I., Papadopoulos, D., & Gauvreau, E. (2013). Stigma in school-based mental health: perceptions of young people and service providers. *Child and Adolescent Mental Health*, 18(3), 165-170.

Bowlby, J. (1969). *Attachment and loss*. New York: Basic Books.

Bowlby, J. (1988). Developmental psychiatry comes of age. *The American journal of psychiatry*, 145(1), 1. <https://doi.org/10.1176/ajp.145.1.1>

Brandon, M., Sidebotham, P., Bailey, S., & Belderson, P. (2011). A study of recommendations arising from serious case reviews 2009-2010. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/182521/DFE-RR157.pdf

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <http://dx.doi.org/10.1191/1478088706qp063oa>

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. London: Sage.

British Psychological Society (2014). *Code of Human Research Ethics*. Retrieved from: <https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Human%20Research%20Ethics.pdf>

British Psychological Society (2018). *Child mental health green paper is a missed opportunity*. Retrieved from <https://www.bps.org.uk/news-and-policy/child-mental-health-green-paper-missed-opportunity>

British Psychological Society (2018a). *Code of Ethics and Conduct*. Retrieved from <https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Ethics%20and%20Conduct%20%28Update%20July%202018%29.pdf>

- Brockington, I., Chandra, P., Dubowitz, H., Jones, D., Moussa, S., Nakku, J., & Quadros Ferre, I. (2013). WPA Guidance on the protection and promotion of mental health of children of persons with severe mental illness. *World Psychiatry*, 10(2), 93–102. <https://doi.org/10.1002/j.2051-5545.2011.tb00023.x>
- Bronfenbrenner, U. (1979). *The ecology of human development*. Massachusetts: Harvard university press.
- Bronte-Tinkew, J., Moore, K. A., Matthews G., & Carrano J. (2007). Symptoms of major depression in a sample of fathers of infants. *Journal of Family Issues*, 28, 61-99. <https://doi.org/10.1177%2F0192513X06293609>
- Brownlie, Z. (2014). *Written evidence from Dr Zoe Brownlie*. Retrieved from <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-and-social-care-committee/transforming-children-and-young-peoples-mental-health-provision/written/76887.pdf>
- Bruland, D., Lenz, A., & Wahl, P. (2017). The perspective of families affected by parental mental illness on stigma and help-seeking. *European Journal of Public Health*, 27(3). <https://doi.org/10.1093/eurpub/ckx189.199>
- Bruland, D., Pinheiro, P., Bröder, J., Okan, O., Carvalho, G. S. D., Saboga-Nunes, L., Bond, E., Wahl, P. Fretian, A. & Bauer, U. (2017). Teachers' supporting students with parents having mental health problems. A scoping review. *International Journal of Case Studies*, 6(9), 1-15. Retrieved from <http://hdl.handle.net/1822/46661>
- Bryman, A. (1988). *Quantity and Quality in Social Research*. London: Unwin Hyman.
- Cameron, R. J. (2006). Educational psychology: The distinctive contribution. *Educational Psychology in Practice*, 22(4), 289-304. <https://doi.org/10.1080/02667360600999393>
- Cane, F. E., & Oland, L. (2015). Evaluating the outcomes and implementation of a TaMHS (Targeting Mental Health in Schools) project in four West Midlands (UK) schools using activity theory. *Educational Psychology in Practice*, 31(1), 1-20. <https://doi.org/10.1080/02667363.2014.975784>
- Care Quality Commission. (2017). *Review of children and young people's mental health services: Phase one report*. Retrieved from https://www.cqc.org.uk/sites/default/files/20171103_cypmhphase1_report.pdf

- Care Quality Commission. (2018). *The state of care in mental health services 2014-2017: findings from CQC's programme of comprehensive inspections of specialist mental health services*. Retrieved from: https://www.cqc.org.uk/sites/default/files/20170720_stateofmh_report.pdf
- Carers Trust (2019). *About young carers*. Retrieved from: <https://carers.org/about-us/about-young-carers>
- Centre for Mental Health. (2017). *Mental health among children and young people: The mental health spectrum*. Retrieved from: <https://www.centreformentalhealth.org.uk/mental-health-among-children-and-young-people>
- Charles, G., Reupert A., & Maybery, D. (2016). Families where a parent has a mental illness. *Child and Youth Services*, 37(2), 95-97. <https://doi.org/10.1080/0145935X.2016.1104032>
- Children's Commissioner (2016). *The support provided to young carers in England*. Retrieved from: <https://www.childrenscommissioner.gov.uk/wp-content/uploads/2017/06/Young-Carers-report-December-2016.pdf>
- Children's Commissioner (2017). Briefing: Children's mental healthcare in England. London: Children's Commissioner. Retrieved from: <https://www.childrenscommissioner.gov.uk/wp-content/uploads/2017/10/Childrens-Commissioner-for-England-Mental-Health-Briefing-1.1.pdf>
- Cicchetti, D., Rogosch, F. A., & Toth, S. L. (1998). Maternal depressive disorder and contextual risk: Contributions to the development of attachment insecurity and behavior problems in toddlerhood. *Development and psychopathology*, 10(2), 283-300. <https://psycnet.apa.org/doi/10.1017/S0954579498001618>
- Cleaver, H., Unell, I. & Aldgate, J. (2011). *Children's needs – parenting capacity. Child abuse: Parental mental illness, learning disability, substance misuse, and domestic violence* (2nd ed.). Norwich: The Stationery Office.
- Clements, P. T., Benasutti, K. M., & Henry, G. (2001). Drawing from experience: Using drawing to facilitate communication and understanding with children exposed to sudden traumatic death. *Journal of Psychosocial Nursing*, 39, 13–20. <https://doi.org/10.3928/0279-3695-20011201-08>

- Cogan, N. (2004). Children caring for parents with mental illness: Perspectives of young carers, parents and professionals and children of disabled parents: New thinking about families affected by disability and illness. *Child and Family Social Work*, 9(3), 313-315. https://doi.org/10.1111/j.1365-2206.2004.00331_6.x
- Cogan, N., Riddell, S., & Mayes, G. (2005). The understanding and experiences of children affected by parental mental health problems: a qualitative study. *Qualitative Research in Psychology*, 2(1), 47– 66. <https://doi.org/10.1191/1478088705qp024oa>
- Compas, B. E., Connor-Smith, J., Saltzman, H., Thomsen, A. H., & Wadsworth, M. E. (2001). Coping with stress during childhood and adolescence: Problems, progress, and potential in theory and research. *Psychological Bulletin*, 127(1), 87-127. <http://dx.doi.org/10.1037/0033-2909.127.1.87>
- Cooklin, A. (2006). Children as carers of parents with mental illness. *Psychiatry*, 5(1), 32-35. <https://doi.org/10.1383/psyt.2006.5.1.32>
- Cooklin, A. (2010). 'Living upside down': being a young carer of a parent with mental illness. *Advances in psychiatric treatment*, 16(2), 141-146. <https://doi.org/10.1192/apt.bp.108.006247>
- Cooklin, A. (2013). Promoting children's resilience to parental mental illness: engaging the child's thinking. *Advances in psychiatric treatment*, 19, 229-240. <https://doi.org/10.1192/apt.bp.111.009050>
- Cooklin, A. (2015). *Have you heard of COPMI?* Retrieved from: <https://ourtime.org.uk/stories/have-you-heard-of-copmi/>
- Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. London: Sage Publications
- Curran, A., Gersch, I. S., & Wolfendale, S. (2003). Educational psychology. In R. Bayne & I. Horton (Eds.), *Applied psychology: Current issues and new directions*. London: Sage.
- Darlington, Y., & Feeney, J. A. (2009). Clients' and professionals' experiences of traversing mental health and child protection systems: Implications for practice.

Families in Society, 90(4), 382–389. <https://doi.org/10.1606%2F1044-3894.3924>

Dearden, C., & Becker, S. (2004). *Young carers in the UK: the 2004 report*. Retrieved from <https://www.lboro.ac.uk/microsites/socialsciences/ycrg/youngCarersDownload/YCReport2004%5b1%5d.pdf>

Department for Education (2010). *Me and my school: Findings from the national evaluation of Targeted Mental Health in Schools 2008–2011*. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/184060/DFE-RR177.pdf

Department for Education (2018). *Mental health and behaviour in schools*. Retrieved from [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/755135/Mental health and behaviour in schools_.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/755135/Mental_health_and_behaviour_in_schools_.pdf)

Department of Health (2015). *Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing*. Retrieved from [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens Mental Health.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf)

Department of Health & Department for Education (2017). *Transforming Children and Young People's Mental Health Provision: a Green Paper*. Retrieved from [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664855/Transforming children and young people s mental health provision.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664855/Transforming_children_and_young_people_s_mental_health_provision.pdf)

Department of Health and Social Care & Department for Education (2018). *Government Response to the Consultation on Transforming Children and Young People's Mental Health Provision: a Green Paper and Next Steps*. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/728892/government-response-to-consultation-on-transforming-children-and-young-peoples-mental-health.pdf

Duncan, S. & Reder, P. (2000). Children's experience of major psychiatric disorder in their parent: an overview. In P. Reder, M. McClure & A. Jolley (Eds.). *Family*

Matters: Interfaces Between Child and Adult Mental Health (pp. 83–95).
London: Routledge.

Durlak, J. A., Weissberg, R. P., Dymnicki, A. B., Taylor, R. D., & Schellinger, K. B. (2011). The impact of enhancing students' social and emotional learning: A meta-analysis of school-based universal interventions. *Child development*, 82(1), 405-432.
<http://dx.doi.org/10.1111/j.14678624.2010.01564.x>

Dyregrov, A. (2001). Telling the truth or hiding the facts. An evaluation of current strategies for assisting children following adverse events. *Association for Child Psychology and Psychiatry Occasional Papers*, 17, 25–38.

Dyregrov, A. (2010). *Supporting Traumatized Children and Teenagers*. London: Jessica Kingsley Publishers.

Ecclestone, K. (2012). From emotional and psychological well-being to character education: challenging policy discourses of behavioural science and 'vulnerability'. *Research Papers in Education*, 27(4), 463-480.
<https://doi.org/10.1080/02671522.2012.690241>

Epstein, J. L. (1995). School/Family/Community Partnerships. *Phi delta kappan*, 76(9), 701.
<https://search.proquest.com/saveasdownloadprogress/41356601E2164033PQ/firstpage?accountid=10792>

Epstein, J. L. (2010). School/Family/Community Partnerships: Caring for the Children We Share. *Phi Delta Kappan*, 92(3), 81–96.
<https://doi.org/10.1177%2F003172171009200326>

Engel, B. S. (1995). *Considering children's art: Why and how to value their works*. Washington DC: National Association for the Education of Young Children.

Engel, G. L. (1977). The need for a new medical model: a challenge for biomedicine. *Science*, 196(4286), 129-136. <http://dx.doi.org/10.1126/science.847460>

Evans, G. W. (2003). A multimethodological analysis of cumulative risk and allostatic load among rural children. *Developmental Psychology*, 39, 924–933.
<http://dx.doi.org/10.1037/0012-1649.39.5.924>

- Evans, J., & Fowler, R. (2008). *Family Minded: supporting children in families affected by mental illness*. Retrieved from http://www.barnardos.org.uk/family_minded_report.pdf
- Fadden, G., & Heelis, R. (2011). The Meriden Family Programme: lessons learned over 10 years. *Journal of Mental Health*, 20(1), 79-88. <http://dx.doi.org/10.3109/09638237.2010.492413>.
- Farrell, P., Woods, K., Lewis, S., Rooney, S., Squires, G., & O'Connor, M. (2006). *The future of educational psychologists within the new children's services*. Retrieved from <https://thepsychologist.bps.org.uk/volume-19/edition-10/online-only-future-educational-psychologists-within-new-childrens-services>
- Falkov, A. (1996). *Study of Working Together 'Part 8' reports. Fatal child abuse and parental psychiatric disorder: An analysis of 100 area child protection committee case reviews conducted under the terms of Part 8 of Working Together under the Children Act 1989*. <https://doi.org/10.1080/09585189708412006>
- Falkov, A. (2012). *The Family Model Handbook: An integrated approach to supporting mentally ill parents and their children*. East Sussex: Pavilion Publishing and Media.
- Falkov, A., Goodyear, M., Hosman, C. M., Biebel, K., Skogøy, B. E., Kowalenko, N., Wolf, T & Re, E. (2016). A systems approach to enhance global efforts to implement family-focused mental health interventions. *Child & Youth Services*, 37(2), 175-193. <https://doi.org/10.1080/0145935X.2016.1104104>
- Falkov, A. & Lindsey, C. (2002). Patients as parents: addressing the needs, including the safety, of children whose parents have mental illness. Retrieved from https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr164.pdf?sfvrsn=79416179_2
- Fallon, K., Woods, K., & Rooney, S. (2010). A discussion of the developing role of educational psychologists within Children's Services. *Educational Psychology in Practice*, 26(1), 1-23. <https://doi.org/10.1080/02667360903522744>
- Falloon, I. R. (2003). Family interventions for mental disorders: efficacy and effectiveness. *World Psychiatry*, 2(1), 20. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1525058/>

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P. & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American journal of preventive medicine*, 14(4), 245-258.

[http://dx.doi.org/10.1016/S0749-3797\(98\)00017-8](http://dx.doi.org/10.1016/S0749-3797(98)00017-8)

Flick, U. (2009). *An Introduction to Qualitative Research* (4th edition). London: Sage.

Fone, F., Dunstan, K., Lloyd, K., Williams, G., Watkins, J & Palmer, S. (2007). Does social cohesion modify the association between area income deprivation and mental health? A multilevel analysis. *International Journal of Epidemiology*, 36(2), 338-345. <https://doi.org/10.1093/ije/dym004>

Foster K. (2010). You'd think this roller coaster was never going to stop': Experiences of adult children of parents with mental illness. *Journal of Clinical Nursing*, 19(31), 43-51. <http://dx.doi.org/10.1111/j.1365-2702.2010.03293>

Foster, K., O'Brien, L., & Korhonen, T. (2012). Developing resilient children and families when parents have mental illness: A family-focused approach. *International journal of mental health nursing*, 21(1), 3-11. <http://dx.doi.org/10.1111/j.1447-0349.2011.00754>

Frey, J. H., & Fontana, A. (1991). The group interview in social research. *The Social Science Journal*, 28(2), 175-187. [https://doi.org/10.1016/0362-3319\(91\)90003-M](https://doi.org/10.1016/0362-3319(91)90003-M)

Gaskell, S., & Leadbetter, J. (2009). Educational psychologists and multi-agency working: exploring professional identity. *Educational Psychology in Practice*, 25(2), 97-111. <https://doi.org/10.1080/02667360902905031>

Gatsou, L., Yates, S., Goodrich, N., & Pearson, D. (2017). The challenges presented by parental mental illness and the potential of a whole-family intervention to improve outcomes for families. *Child & Family Social Work*, 22(1), 388-397. <https://doi.org/10.1111/cfs.12254>

Gibbs, A. (1997). *Social Research Update: Focus Groups*. Retrieved from: <http://sru.soc.surrey.ac.uk/SRU19.html>

- Grace, S. L., Evindar, A., & Stewart, D. E. (2003). The effect of postpartum depression on child cognitive development and behavior: a review and critical analysis of the literature. *Archives of women's mental health*, 6(4), 263-274.
<http://dx.doi.org/10.1007/s00737-003-0024-6>
- Gray, B., Robinson, C., & Seddon, D. (2008). Invisible Children: Young Carers of Parents with Mental Health Problems-The Perspectives of Professionals. *Child and Adolescent Mental Health*, 13(4), 169-172. <https://doi.org/10.1111/j.1475-3588.2007.00477.x>
- Grove, C., Reupert, A. and Maybery, D. (2013). Gaining knowledge about parental mental illness: how does it empower children? *Child and family social work*, 20(4), 377-386. <https://doi.org/10.1111/cfs.12086>
- Grove, C., Riebschleger, J., Bosch, A., Cavanaugh, D., & van der Ende, P. C. (2017). Expert views of children's knowledge needs regarding parental mental illness. *Children and Youth Services Review*, 79, 249-255.
<https://doi.org/10.1016/j.childyouth.2017.06.026>
- Hagerty, B. M. K., Lynch-Sauer, J., Patusky, K. L., Bouwsema, M., & Collier, P. (1992). Sense of Belonging: A Vital Mental Health Concept. *Archives of Psychiatric Nursing*, 6(3), 172-177. [https://doi.org/10.1016/0883-9417\(92\)90028-H](https://doi.org/10.1016/0883-9417(92)90028-H)
- Hall, A. (1996). Parental psychiatric disorder and the developing child. In M. Gopfort, J. Webster & M. V. Seeman (Eds.), *Parental psychiatric disorder: Distressed parents and their families* (pp. 22-49). Cambridge: Cambridge University Press.
- Harvey, C. & Brophy, L. (2011). Social isolation in people with mental illness. *Medicine Today*, 12(10), 73-78. <http://dx.doi.org/610.1007/s00127-017-1446-1>
- Hayes, D., & Spratt, T. (2009). Child welfare interventions: Patterns of social work practice. *British Journal of Social Work*, 39(8), 1575-1597.
<https://doi.org/10.1093/bjsw/bcy001>
- Heads Together (2018). *Mental health: Why it's important to schools*. Retrieved from <https://www.mentallyhealthyschools.org.uk/whats-mental-health/>
- Henshaw, C., Adshead, G., & Bende, B. (2011). *Parents as patients: supporting the needs of patients who are parents and their children*. Retrieved from

https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr164.pdf?sfvrsn=79416179_2

Her Majesty's Government (2015). *Working Together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children*. London: Crown.

Hinshaw, S. P. (2009). *The mark of shame: Stigma of mental illness and an agenda for change*. London: Oxford University Press.

Hinshaw, S. P. (2018). The Development of Children when a Parent Experiences Mental Disorder: Stigma, Communication, and Humanization. *Human Development*, 61(65), 70. <https://doi.org/10.1159/000487748>

Hippwell, A., Goossens, F. A., Melhuish, E. C., & Kumar, R. (2000). Severe maternal psychopathology and infant-mother attachment. *Development and Psychopathology*, 12(2), 157-175. <https://doi.org/10.1017/S095457940000203>

Hogg, S. (2013). *Prevention in mind: All Babies Count: spotlight on perinatal mental health*. London: NSPCC.

Holloway, I. & Wheeler, S. (2010). *Qualitative Research in Nursing and Healthcare* (3rd Edition). Chichester: Wiley-Blackwell.

Holstein, J. A., & Gubrium, J. F., (2004). The active interview. In D. Silverman (Ed.), *Qualitative Research: Theory, Method and Practice* (pp 138-161). London: Sage.

Hosman, C. M., van Doesum, K. T., & van Santvoort, F. (2009). Prevention of emotional problems and psychiatric risks in children of parents with a mental illness in the Netherlands: The scientific basis to a comprehensive approach. *Australian e-Journal for the Advancement of Mental health*, 8(3), 250-263. <https://doi.org/10.5172/jamh.8.3.250>

House of Commons Education Committee (2018). *Forgotten children: alternative provision and the scandal of ever increasing exclusions*. Retrieved from <https://publications.parliament.uk/pa/cm201719/cmselect/cmeduc/342/342.pdf>

House of Commons Education and Health and Social Care Committees (2018). *The Government's Green Paper on mental health: failing a generation*. Retrieved from <https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/642/642.pdf>

- Howland, A., Anderson, J., Smiley, A., & Abbott, D. (2006). School liaisons: Bridging the gap between home and school. *School Community Journal*, 16(2), 47–68. Retrieved from <https://psycnet.apa.org/record/2006-22286-004>
- Hutchings, M. (2015). Exam factories. *The impact of accountability measures on children and young people*. National Union of Teachers: London.
- Johnston, D. W., Schurer, S., & Shields, M. A. (2013). Exploring the intergenerational persistence of mental health: Evidence from three generations. *Journal of Health Economics*, 32(6), 1077-1089. <https://doi.org/10.1016/j.jhealeco.2013.09.001>
- Jopling, M., & Vincent, S. (2016). *Vulnerable Children: Needs and Provision in the Primary Phase*. York: Cambridge Primary Review Trust.
- Kahn, L. (2016). *Missed opportunities: A review of recent evidence into children and young people's mental health*. Retrieved from <https://www.centreformentalhealth.org.uk/Handlers/Download.ashx?IDMF=37cccf4c-c86b-4e64-ba8c-e7774cac66c7>
- Katz, I., & Hetherington, R. (2006). Co-operating and communicating: a European perspective on integrating services for children. *Child Abuse Review*, 15(6), 429-439. <https://doi.org/10.1002/car.965>
- Kern, L., Mathur, S. R., Albrecht, S. F., Poland, S., Rozalski, M., & Skiba, R. J. (2017). The need for school-based mental health services and recommendations for implementation. *School Mental Health*, 9(3), 205-217. <https://doi.org/10.1007/s12310-017-9216-5>
- Keshavan, M., Montrose, D. M., Rajarethinam, R., Diwadkar, V., Prasad, K., & Sweeney, J. A. (2008). Psychopathology among offspring of parents with schizophrenia: relationship to premorbid impairments. *Schizophrenia research*, 103(1), 114-120. <http://dx.doi.org/10.1016/j.schres.2008.03.006>
- Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of general psychiatry*, 62(6), 593-602. <http://dx.doi.org/10.1001/archpsyc.62.6.593>

- Kim, B. (2001). Social constructivism. *Emerging perspectives on learning, teaching, and technology*, 1(1), 16. Retrieved from <http://www.coe.uga.edu/epltt/SocialConstructivism.htm>
- Kinderman, P. (2005). A psychological model of mental disorder. *Harvard Review of Psychiatry*, 13, 206 – 217. <http://dx.doi.org/10.1080/10673220500243349>
- Kinderman, P., Schwannauer, M., Pontin, E., & Tai, S. (2013). Psychological Processes Mediate the Impact of Familial Risk, Social Circumstances and Life Events on Mental Health. *PLoS ONE*, 8(10). <https://doi.org/10.1371/journal.pone.0076564>
- Kinderman, P. (2017). *BPS response to Theresa May's Speech*. Retrieved from <https://www.bps.org.uk/news-and-policy/bps-response-theresa-mays-speech-mental-health>
- Kinderman, P., Sellwood, W., & Tai, S. (2008). Policy implications of a psychological model of mental disorder. *Journal of Mental Health*, 17(1), 93-103. <http://dx.doi.org/10.1080/09638230701530226>
- King, N. (2004). Using templates in the thematic analysis of texts. In C. Cassell & G. Symon (Eds.), *Essential guide to qualitative methods in organizational research* (pp. 256-270). London: Sage.
- Krueger, R. A. & Casey, M. A. (2009). *Focus Groups: A Practical Guide for Applied Research* (4th edition). California: Sage.
- Lyons-Ruth, K., & Jacobvitz, D. (1999). Attachment disorganization: Unresolved loss, relational violence, and lapses in behavioral and attentional strategies. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 520-554). New York: Guilford Press.
- Mackereth, S., Göpfert, M., Harrison P., & Mahoney, S. (1999). *Keeping the Family in Mind. Participative Research into Mental Ill-Health and How it Affects the Whole Family*. North Mersey: Barnado's
- Maslow, A. H. (1943). A theory of human motivation. *Psychological review*, 50(4), 370. <http://dx.doi.org/10.1037/h0054346>
- Maslow, A. H. (1954). *Motivation and personality*. Oxford: Harpers.

- Maybery, D., & Reupert, A. (2009). Parental mental illness: a review of barriers and issues for working with families and children. *Journal of Psychiatric and Mental Health Nursing*, 16(9), 784-791. <http://dx.doi.org/10.1111/j.1365-2850.2009.01456.x>
- Mazzer, K. R., & Rickwood, D. J. (2015). Teachers' role breadth and perceived efficacy in supporting student mental health. *Advances in School Mental Health Promotion*, 8(1), 29-41. <https://doi.org/10.1080/1754730X.2014.978119>
- Mentally Healthy Schools (2019). *Parent / carer engagement*. Retrieved from <https://www.mentallyhealthyschools.org.uk/whole-school-approach/parentcarer-engagement/>
- Murphy, G., Peters, K., Wilkes, L. & Jackson, D. (2015). Childhood Parental Mental Illness: Living with Fear and Mistrust. *Issues in Mental Health Nursing*, 36(4), 294-299. <http://dx.doi.org/10.3109/01612840.2014.971385>
- Murphy, G., Peters, K., Wilkes, L. & Jackson, D. (2016). Adult children of parents with mental illness: losing oneself. Who am I? *Issues in mental health nursing*, 37(9), 668-673. <http://dx.doi.org/10.1080/01612840.2016.1178359>
- Naughton, M. F. A., Maybery, D. J. & Goodyear, M. (2018). Prevalence of mental illness within families in a regional child-focussed mental health service. *International Journal of Mental Health Nursing*, 27, 901–910. <https://doi.org/10.1111/inm.12386>
- National Child and Maternal Health Intelligence Network. (2011) *TaMHS Final Evaluations*. Retrieved from <http://www.chimat.org.uk/camhs/tamhs/eval>.
- National Society for the Prevention of Cruelty to Children (2015). *Parents with a mental health problem: learning from case reviews*. Retrieved from https://learning.nspcc.org.uk/media/1349/learning-from-case-reviews_parents-with-a-mental-health-problem.pdf
- National Institute for Health and Care Excellence (2008). *Social and emotional wellbeing in primary education*. Retrieved from <https://www.nice.org.uk/guidance/ph12>
- National Institute for Health and Care Excellence (2009). *Social and emotional wellbeing in secondary education*. Retrieved from <https://www.nice.org.uk/guidance/ph20>

- Newman, L., & Stevenson, C. (2005). Parenting and borderline personality disorder: ghosts in the nursery. *Clinical Child Psychology and Psychiatry*, 10(3), 385-394. <https://doi.org/10.1177%2F1359104505053756>
- Nicholson, J., & Biebel, K. (2002). Commentary on 'Community Mental Health Care for Women with Severe Mental Illness Who are Parents: The Tragedy of missed opportunities: What providers can do'. *Community Mental Health Journal*, 38(2), 167–172. Retrieved from <https://link.springer.com/article/10.1023%2FA%3A1014551306288>
- Nicholson, J., Nason, M. W., Calabresi, A. O., & Yando, R. (1999). Fathers with severe mental illness: Characteristics and comparisons. *American Journal of Orthopsychiatry*, 69(1), 134. <https://doi.org/10.1037/h0080390>
- Nilsson, S., Gustafsson, L., Nolbris, M. J. (2015). Young adults' childhood experiences of support when living with a parent with mental illness. *Journal of Child Health Care*, 19(4), 444–53. <https://doi.org/10.1177%2F1367493513519296>
- Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, 16(1). <http://dx.doi.org/10.1177/1609406917733847>
- Oates, M. (1997). Patients as parents: The risk to children. *The British Journal of Psychiatry*, 170(32), 22-27. <https://doi.org/10.1192/S0007125000298681>
- O'Connor, T. G., Heron, J., Golding, J., & Glover, V. (2003). Maternal antenatal anxiety and behavioural/emotional problems in children: a test of a programming hypothesis. *Journal of child Psychology and Psychiatry*, 44(7), 1025-1036. <https://doi.org/10.1111/1469-7610.00187>
- Office of the Deputy Prime Minister (2004). *Mental health and social exclusion, Social Exclusion Unit Report*. Retrieved from https://www.centreformentalhealth.org.uk/sites/default/files/mental_health_and_social_exclusion.pdf
- Ofsted (2013). *What about the children? Joint working between adult and children's services when parents or carers have mental ill health and/or drug and alcohol problems*. Retrieved from <https://www.gov.uk/government/publications/joint-working-between-adult-and-childrens-services>

- Ofsted (2019). *Education inspection framework: a report on the responses to the consultation*. Retrieved from <https://www.gov.uk/government/consultations/education-inspection-framework-2019-inspecting-the-substance-of-education>
- O'Hare, D. (2017). *Where are the EPs? Theresa May, Mental Health and Schools*. Retrieved from <https://edpsy.org.uk/blog/2017/eps-theresa-may-mental-health-schools/>
- Our Time Foundation (2019). *Kidstime Workshops*. Retrieved March 5, 2019 from <https://ourtime.org.uk/ourwork/kidstime-workshops/>
- Our Time Foundation (2017). *Our Impact*. Retrieved December 13, 2017 from <http://kidstimefoundation.org/whowehelp/how-we-help/>
- Owens, C., Crone, D., Kilgour, L., & El Ansari, W. (2010). The place and promotion of well-being in mental health services: A qualitative investigation. *Journal of psychiatric and mental health nursing*, 17(1), 1-8. <https://doi.org/10.1111/j.1365-2850.2009.01480.x>
- Oyserman, D. Bybee, D., Mowbray, C., & Hart-Johnson, T. (2005). When mothers have serious mental health problems: parenting as a proximal mediator. *Journal of Adolescence*, 28, 443-463. <http://dx.doi.org/10.1016/j.adolescence.2004.11.004>
- Pape, S. E., & Collins, M. P. (2011). A systematic literature review of parenting behaviours exhibited by anxious people. *European Psychiatry*, 26, 170. [https://doi.org/10.1016/S0924-9338\(11\)71881-8](https://doi.org/10.1016/S0924-9338(11)71881-8)
- Petrowski, C., & Stein, C. H. (2016). Young women's accounts of caregiving, family relationships, and personal growth when mother has mental illness. *Journal of Child and Family Studies*, 25, 2873–84. <http://dx.doi.org/10.1007/s10826-016-0441-6>
- Powell, R. & Single, H. (1996). 'Focus groups', *International Journal of Quality in Health Care*, 8(5), 499-504. <https://doi.org/10.1093/intqhc/8.5.499>
- Power, J., Goodyear, M., Maybery, D., Reupert, A., O'Hanlon, B., Cuff, R., & Perlesz, A. (2016). Family resilience in families where a parent has a mental illness. *Journal of Social Work*, 16(1), 66-82. <https://doi.org/10.1177%2F1468017314568081>

- Price, R. (2017). *The Role of the Educational Psychologist in Children and Young People's Mental Health: An Explorative Study in Wales*. (Doctoral Thesis). Retrieved from <https://orca.cf.ac.uk/104818/1/2017pricededpsy.pdf>
- Public Health England (2018). *Public Mental Health*. Retrieved from <https://www.gov.uk/government/collections/public-mental-health>
- Reicher, S. D., Spears, R., & Postmes, T. (1995). A social identity model of deindividuation phenomena. *European review of social psychology*, 6(1), 161-198. <https://doi.org/10.1080/14792779443000049>
- Reupert, A., & Maybery, D. (2009) A 'snapshot' of Australian programs to support children and adolescents whose parents have a mental illness. *Psychiatric Rehabilitation Journal*, 33(2), 125–132. <http://dx.doi.org/10.2975/33.2.2009.125.132>.
- Reupert, A., & Maybery, D. (2011). Programmes for parents with a mental illness. *Journal of Psychiatric and Mental Health Nursing*, 18(3), 257-264. <http://dx.doi.org/10.1111/j.1365-2850.2010.01660.x>
- Reupert, A., & Maybery, D. (2016). What do we know about families where parents have a mental illness? A systematic review. *Child and Youth Services*, 37(2), 98-111. <https://doi.org/10.1080/0145935X.2016.1104037>
- Reupert, A., Maybery, D. & Kowalenko, N. (2012). Children whose parents have a mental illness: Prevalence, need and treatment. *Medical Journal of Australia*, 16, 7-9. <http://dx.doi.org/10.5694/mja11.11200>
- Riebschleger, J., Grove, C., Cavanaugh, D. & Costello, S. (2017) Mental Health Literacy Content for Children of Parents with a Mental Illness: Thematic Analysis of a Literature Review. *Brain Sciences*, 7(11), 141. <http://dx.doi.org/10.3390/brainsci7110141>
- Ritchie, J., Lewis, J., McNaughton-Nicholls, C., & Ormston, R. (2013). *Qualitative research practice: A guide for social science students and researchers*. London: Sage.
- Robson, C., & McCartan, K. (2016). *Real world research*. Chichester: John Wiley & Sons.
- Rouf, K. (2014). We need to talk: Parental mental health problems and their potential impact on children. *Educational & Child Psychology*, 31(3), 71-84. Retrieved

from

<https://www.researchgate.net/publication/320858954> We need to talk Parental mental health problems and their potential impact on children

Royal College of Psychiatrists (2004). *Child Abuse and Neglect: The Role of Mental Health Services*. Retrieved from www.rcpsych.ac.uk/files/pdfversion/cr120.pdf

Royal College of Psychiatrists (2012). *Parental mental illness: The impact on children and adolescents: Information for parents, carers and anyone who works with young people*. Retrieved from <https://www.rcpsych.ac.uk/mental-health/parents-and-young-people/information-for-parents-and-carers/parental-mental-illness-the-impact-on-children-and-adolescents-for-parents-and-carers>

Rubin, H., & Rubin, I. (2012). *Qualitative Interviewing: the Art of Hearing Data*. London: Sage.

Rutter, M. (1987). Psychosocial Resilience and Protective Mechanisms. *American Journal of Orthopsychiatry*, 57, 316–31. <https://doi.org/10.1111/j.1939-0025.1987.tb03541.x>

Rutter, M. (1999). Resilience concepts and findings: implications for family therapy. *Journal of Family Therapy*, 21, 119–44. <https://doi.org/10.1111/1467-6427.00108>

Rutter, M. (2003). Genetic influences on risk and protection: Implications for understanding resilience. In S. S. Luthar (Ed.), *Resilience and vulnerability: Adaptation in the context of childhood adversities* (pp. 489-509) New York: Cambridge University Press. <http://dx.doi.org/10.1017/CBO9780511615788.022>

Rutter, M. & Quinton, D. (1984). Parental psychiatric disorder: Effects on children. *Psychological Medicine*, 14(4) 853-880. <http://dx.doi.org/10.1017/S0033291700019838>

Sachs-Ericsson, N. J., Sheffler, J. L., Stanley, I. H., Piazza, J. R., & Preacher, K. J. (2017). When emotional pain becomes physical: Adverse childhood experiences, pain, and the role of mood and anxiety disorders. *Journal of Clinical Psychology*, 73(10), 1403-1428. <http://dx.doi.org/10.1002/jclp.22444>.

Sanders, R., Jackson, S., & Thomas, N. (1996). The Balance of Prevention, Investigation and Treatment in the Management of Child Protection Services.

Child Abuse and Neglect, 20(10), 899–906. [https://doi.org/10.1016/0145-2134\(96\)00079-8](https://doi.org/10.1016/0145-2134(96)00079-8)

Sidebotham, P., Brandon, M., Bailey, S., Belderson, P., Dodsworth, J., Garstang, J., Harrison, E., Retzer, A. & Sorensen, P. (2016). Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014: final report. Retrieved from [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/533826/Triennial Analysis of SCRs 2011-2014 - Pathways to harm and protection.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/533826/Triennial_Analysis_of_SCRs_2011-2014_-_Pathways_to_harm_and_protection.pdf)

Slominski, L. J. (2010). *The Effects of Parental Mental Illness on Children: Pathways to Risk to Resilience from Infancy to Adulthood* (Ph.D. dissertation). Retrieved from <http://hdl.handle.net/2027.42/77750>

Smith, M. (2004). Parental mental health: disruptions to parenting and outcomes for children. *Child & Family Social Work*, 9(1), 3-11. <https://doi.org/10.1111/j.1365-2206.2004.00312.x>

Smithson, J. (2010). Using and analysing focus groups: limitations and possibilities. *International journal of social research methodology*, 3(2), 103-119. <https://doi.org/10.1080/136455700405172>

Social Care Institute for Excellence (2009). *Think child, think parent, think family: a guide to parental mental health and child welfare*. Retrieved from <https://www.scie.org.uk/publications/guides/guide30/>

Stallard, P., Norman, P., Huline-Dickins, S., Salter, E., & Cribb, J. (2004). The effects of parental mental illness upon children: A descriptive study of the views of parents and children. *Clinical Child Psychology and Psychiatry*, 9(1), 39 – 52. <https://doi.org/10.1177%2F1359104504039767>

Stewart-Brown, S. L. & Schrader-McMillan, A. (2011). Parenting for mental health: what does the evidence say we need to do? Report of Workpackage 2 of the Data Prev project. *Health Promotion International*, 26(1), 10-28. <http://dx.doi.org/10.1093/heapro/dar056>

Stobie, I., Boyle, J., & Woolfson, L. (2005). Solution-focused approaches in the practice of UK educational psychologists: A study of the nature of their

application and evidence of their effectiveness. *School Psychology International*, 26(1), 5-28. <https://doi.org/10.1177%2F0143034305050890>

Stuart, H. (2016). Reducing the stigma of mental illness. *Global Mental Health*, 3, 17. <http://dx.doi.org/10.1017/gmh.2016.11>

Tabak, I., Zabłocka-Żytka, L., Ryan, P., Poma, S. Z., Joronen, K., Viganò, G., Simpson, W., Paavilainen, E., Scherbaum, N., Smith, M., & Dawson, I. (2016). Needs, expectations and consequences for children growing up in a family where the parent has a mental illness. *International journal of mental health nursing*, 25(4), 319-329. <http://dx.doi.org/10.1111/inm.12194>

Thanhäuser, M., Lemmer, G., de Girolamo, G., & Christiansen, H. (2017). Do preventive interventions for children of mentally ill parents work? Results of a systematic review and meta-analysis. *Current Opinion in Psychiatry*, 30(4), 283-299. <http://dx.doi.org/10.1097/YCO.0000000000000342>.

Thomas, G. (2017). *How to do your research project*. London: Sage.

Thomas, L., & Kalucy, R. (2003). Parents with mental illness: Lacking motivation to parent. *International Journal of Mental Health Nursing*, 12(2), 153-157. <https://doi.org/10.1046/j.1440-0979.2003.00282.x>

The Children's Society (2008a). *The Good Childhood Inquiry: health research evidence*. Retrieved from https://www.childrenssociety.org.uk/sites/default/files/tcs/research_docs/good%20childhood%20national%20inquiry.pdf

The Children's Society (2008b). *Young Carer's Initiative: Emotional support for young carers: A report prepared for the Royal College of Psychiatrists*. Retrieved from <https://www.rcpsych.ac.uk/mental-health/parents-and-young-people/information-for-parents-and-carers/parental-mental-illness-the-impact-on-children-and-adolescents-for-parents-and-carers>

The Children's Society (2013). *Hidden from view: The experiences of young carers in England*. Retrieved from https://www.childrenssociety.org.uk/sites/default/files/tcs/report_hidden-from-view_young-carers_final.pdf

- Tienari, P., Wahlberg, K. E., & Wynne, L. C. (2006). Finnish adoption study of schizophrenia: Implications for family interventions. *Families, Systems, & Health*, 24(4), 442-451. <http://dx.doi.org/10.1037/1091-7527.24.4.442>
- Tienari, P., Wynne, L. C., Sorri, A., Lahti, I., Läksy, K., Moring, J., Naarala, M., Nieminen, P. & Wahlberg, K. E. (2004). Genotype-environment interaction in schizophrenia-spectrum disorder. *The British Journal of Psychiatry*, 184(3), 216-222. <http://dx.doi.org/10.1192/bjp.184.3.216>
- Tomlinson, P. (1989). Having it both ways: hierarchical focusing as research interview method. *British Educational Research Journal*, 15(2), 155-176. <https://doi.org/10.1080/0141192890150205>
- Toth, S. L., Rogosch, F. A., Sturge-Apple, M., & Cicchetti, D. (2009). Maternal depression, children's attachment security, and representational development: An organizational perspective. *Child development*, 80(1), 192-208. <http://dx.doi.org/10.1111/j.1467-8624.2008.01254>
- Training and Development Agency for Schools (2009). *Parent support advisers: Practice and Impact*. Retrieved from https://dera.ioe.ac.uk/9461/7/psa_practice_impact_summer2009_Redacted.pdf
- Unison (2018). *Stars in our schools - 2018 survey*. Retrieved from <https://www.unison.org.uk/content/uploads/2018/11/Stars-in-our-schools-report.pdf>
- Van Loon, L., Van de Ven, M., Van Doesum, K., Witteman, C., & Hosman, C. (2014) The Relation Between Parental Mental Illness and Adolescent Mental Health: The Role of Family Factors. *Journal of Child and Family Studies*, 23(7), 1201-1214. <http://dx.doi.org/10.1007/s10826-013-9781-7>
- Van Zomeren, M., Spears, R., & Leach, C. W. (2008). Exploring psychological mechanisms of collective action: Does relevance of group identity influence how people cope with collective disadvantage? *British Journal of Social Psychology*, 47(2), 353-372. <https://doi.org/10.1348/014466607X231091>
- Viganò, G., Kaunonen, M., Ryan, P., Simpson, W., Dawson, I., Tabak, I., Scherbaum, N., & Poma, S. Z. (2017). Are Different Professionals Ready to Support Children of Parents with Mental Illness? Evaluating the Impact of a Pan-European Training Programme. *The journal of behavioral health services & research*, 44(2), 304-315. <https://doi.org/10.1007/s11414-016-9548-1>

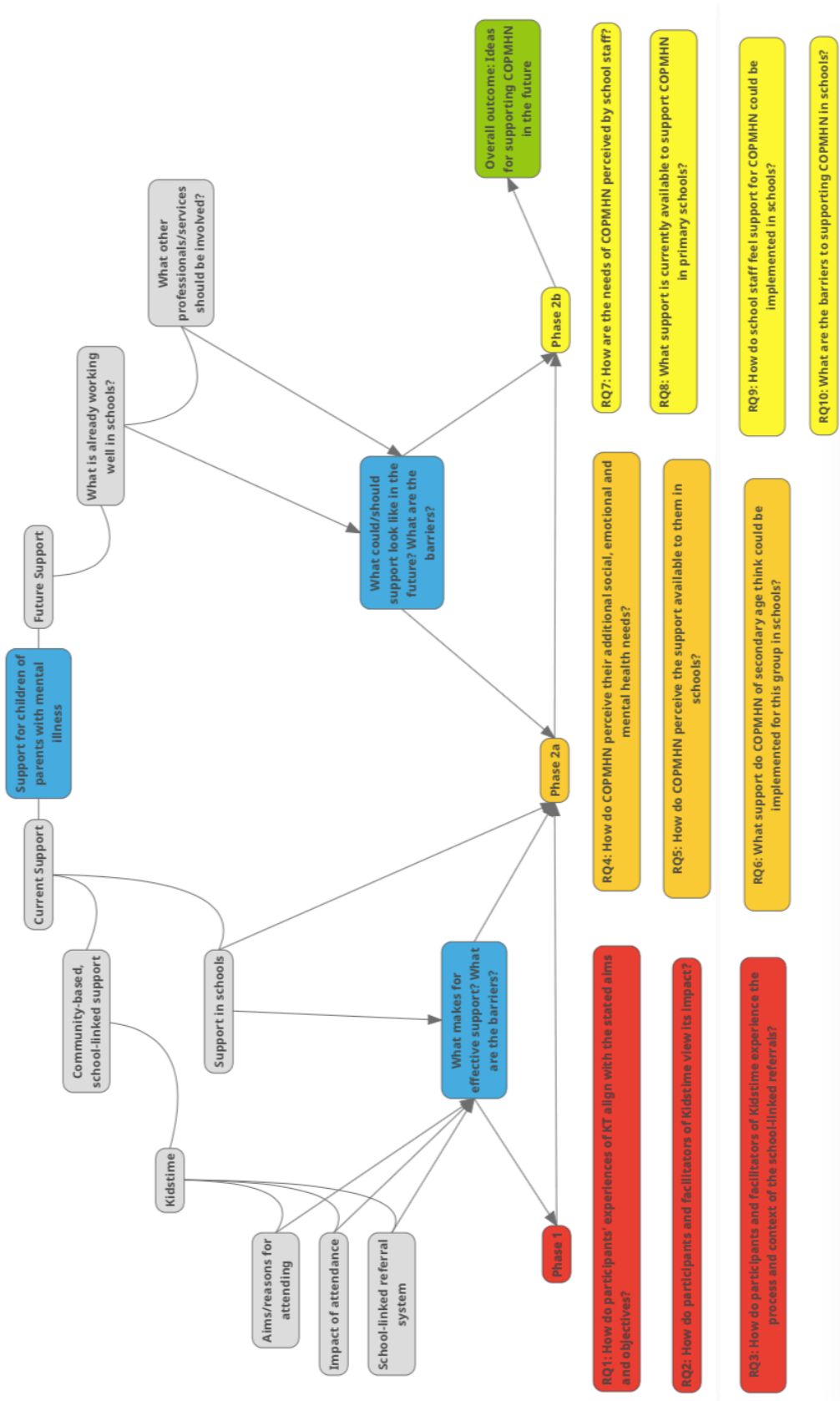
- Vincent, S. (2015). *Early Intervention: Supporting and strengthening families*. Dunedin: Academic Press Ltd.
- Wadey, K. M. (2015). Young Carers' Experiences of Caring in an Inner London Borough – an Interpretative Phenomenological Analysis (Doctoral dissertation). Retrieved from EThOS database (uk.bl.ethos.679206).
- Wagner, P. (2000). Consultation: Developing a comprehensive approach to service delivery. *Educational Psychology in Practice*, 16(1), 9-18.
<https://doi.org/10.1080/026673600115229>
- Weare, K. (2015). *What works in promoting social and emotional well-being and responding to mental health problems in schools? Advice for Schools and Framework Document. Partnership for Wellbeing and Mental Health in Schools*. Retrieved from <https://www.mentalhealth.org.nz/assets/ResourceFinder/What-works-in-promoting-social-and-emotional-wellbeing-in-schools-2015.pdf>
- Weissman, M. M., Wickramaratne, P., Nomura, Y., Warner, V., Pilowsky, D., & Verdeli, H. (2006). Offspring of depressed parents: 20 years later. *American Journal of Psychiatry*, 163(6), 1001-1008. <http://dx.doi.org/10.1176/ajp.2006.163.6.1001>
- Weist, M. D., Lovie, J., Lever, N., Johnson, A., & Rowling, L. (2002). Building an International Network for Mental Health in Schools. *The International Journal of Mental Health Promotion*, 4(2), 34–40.
<http://dx.doi.org/10.1080/14623730.2002.9721859>
- Wolpert, M., Hoffman, J., Martin, A., Fagin, L., & Cooklin, A. (2015). An exploration of the experience of attending the Kidstime programme for children with parents with enduring mental health issues: Parents' and young people's views. *Clinical child psychology and psychiatry*, 20(3), 406-418.
<https://doi.org/10.1177%2F1359104514520759>
- World Health Organisation (2001). *Promoting Mental Health: Summary Report*. Retrieved from
https://www.who.int/mental_health/evidence/en/promoting_mhh.pdf
- World Health Organisation (2014). *Social determinants of mental health*. Retrieved from
https://www.who.int/mental_health/publications/gulbenkian_paper_social_determinants_of_mental_health/en/

- World Health Organisation. (2017). *Gender and women's mental health: Gender disparities and mental health: The Facts*. Retrieved from http://www.who.int/mental_health/prevention/genderwomen/en/
- Wyn, J., Cahill, H., Holdsworth, R., Rowling, L., & Carson, S. (2000). MindMatters, a whole-school approach promoting mental health and wellbeing. *Australian & New Zealand Journal of Psychiatry*, 34(4), 594-601.
<http://dx.doi.org/10.1080/j.1440-1614.2000.00748.x>
- Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and health*, 15(2), 215-228.
- Young Minds (2018a). *Kids in Crisis: Documentary on CAMHS*. Retrieved from <https://youngminds.org.uk/blog/kids-in-crisis-documentary-on-camhs/>
- Young Minds (2018b). *Children's Mental Health Funding: Where Is It going?* Retrieved from <https://youngminds.org.uk/blog/childrens-mental-health-funding-where-is-it-going/>
- Zikmund, W.G. (1997). *Exploring Marketing Research* (6th edition). Texas: The Dryden Press.

Appendices

Appendix A

Concept map to outline the structure and content of the research domain.






Appendix B

Interview schedules for phase 1 participants




Interview schedule designed for children aged 4-7

Issue/topic	Possible Questions	Possible follow-up questions	Probes
Reasons for coming to Kidstime / purpose of Kidstime	1.How did you find out about Kidstime?	Who told you? What did they say?	
	2.What is the point of coming to Kidstime?		
	3.When you did (X) at the beginning of Kidstime today.... What did it make you think about?	Do you think that it could have anything to do with people being unwell? <ul style="list-style-type: none"> Do you know what mental illness means? 	Tell me about that.
Perception of the elements of Kidstime	4.Can you draw your favourite bit of Kidstime?	Tell me about your drawing.	What do you like about that part?
Art work / film description Children will be presented with different pieces of artwork /film they have previously created.	5.Can you tell me about this piece of art work/ film?	What does it mean? What were you trying to show?	

Impact of Kidstime	<p>Has anything changed for you because of Kidstime?</p> <p>For this question, children were given a larger copy of the 'feelings faces' scale to highlight if things were worse, the same, or better than before they attended Kidstime.</p>	<ul style="list-style-type: none"> How you are doing <div> <div>Worse</div> <div>The same</div> <div>Better</div> </div> <div>    </div> <p>(visual prompt used for all of these questions)</p> <ul style="list-style-type: none"> How your family are doing How you are doing at school How you feel about yourself How well you can cope when things are tricky How much you understand about mental illness <p>Is there anything else that has changed for you?</p>	<p>Can you explain?</p> <p>Tell me more about that.</p>
	<p>Perception and understanding of support in schools / elsewhere?</p>	<p>Is there someone in school that knows you come to Kidstime?</p> <p>8. Do you learn about mental illness in school?</p>	<p>Who are they?</p> <p>Does it help to have someone in school that knows about your family?</p> <p>How?</p> <p>What do you learn about?</p>
<p>Is there anything else you want to talk about?</p>			

Interview schedule designed for children aged 7+ for phase 1

Issue/topic	Possible Questions	Possible follow-up questions	Probes
Reasons for coming to Kidstime	How did you find out about Kidstime?	Who told you? Can you tell me what they said? What did you think/feel about coming?	
	Why does your family come to Kidstime?	Does Kidstime help you? How? Do you think Kidstime helps your family?	Can you explain. Tell me more about that.
Perception of the elements of Kidstime	Can you draw your favourite bit of Kidstime?	Can you tell me why you think that bit is the best? Can you explain why? Is there anything you don't like about Kidstime?	
Art work / film description Children will be presented with different pieces of artwork /film they have previously created.	Can you tell me about this piece of art work/ film?	What does it mean? What were you trying to show?	

Impact of Kidstime	<p>Has anything changed for you since coming to Kidstime?</p> <p>Children given larger version of visual prompt for all questions</p>	<p>Has your understanding of mental illness changed?</p> <p>1. How would you explain mental illness to someone who didn't know about it?</p> <p>Have any of these things changed...?</p> <ul style="list-style-type: none"> How you are doing? <div> <div>Worse</div> <div>The same</div> <div>Better</div> </div> <div>    </div> <ul style="list-style-type: none"> How your family are doing? How you get on with friends? How you get on at school? How happy you feel? How you feel about yourself? How well you can cope when things are tricky? <p>Is there anything else that has changed for you?</p>	<p>Can you explain?</p> <p>Tell me more about that.</p>
Perception and understanding of support in schools / elsewhere?	Is there someone in school that knows you come to Kidstime?	<p>Who are they?</p> <p>Do you think it is helpful that someone knows?</p> <p>If yes why/how?</p>	
	Do you learn about mental health or mental illness in school?	Can you tell me about what you learn?	
	Do you have any other help either in	If yes, what is it?	Can you tell me more

	or outside of school that is to do with mental illness?	If no, what would be helpful in school do you think?	about what happens?
	Is there anything else you feel you need help with?	What would it be? How would that help? Is there anything you still don't understand or want to know about mental illness?	
Is there anything else you would like to talk about?			

Interview schedule for parents attending Kidstime workshops

Issue/topic	Possible Questions	Possible follow-up questions	Probes
Reasons for coming to Kidstime	How did you first find out about Kidstime?	Was it through school / health services? Did you request some support? OR Did school or other services suggest support was needed for yourself/your child?	Tell me more about that. Can you explain what support you felt you/your child needed. Can you explain what support the school / other service felt was needed? What did you think/feel about that?
	Why do you come to Kidstime?	What first brought you here? What is the purpose of Kidstime for you? Who do you feel benefits from Kidstime? What do you think are the benefits of coming to Kidstime? / What do you like about it?	Tell me more about that.
Perception of the elements of Kidstime	How do you feel about the seminar aspect of the group (the beginning discussion)?	What do you think is the point of it? Is there a benefit?	Can you explain?

	How do you feel about the shared activities aspect of Kidstime?	What do you think is the point of it? What do you like /not like about it?	
	How do you feel about the separate group section of Kidstime?	What do you feel is the point of it? Do you gain anything from attending? If so what?	Can you explain...
	How do you feel about the final part of Kidstime where progress is shared and time is spent sharing food together?	What do you feel is the purpose? Is this beneficial for you?	Tell me more about that.
Impact of Kidstime	Has anything changed for you as a result of attending Kidstime?	In terms of; Your knowledge and understanding of mental health and illness? Relationships? With your child/children With anyone else? The way you talk about mental illness? Home life in general? Sense of wellbeing? The state of being comfortable, happy and feeling okay about yourself. Resilience?	Can you explain the change? Can you give an example?

		<p>The ability to deal with difficult situations and cope in hard times.</p> <p>Self-concept?</p> <p>How you think and feel about yourself and how you feel others perceive you.</p> <p>Any other impact?</p>	
	<p>Do you feel anything has changed for your child as a result of Kidstime?</p>	<p>In terms of;</p> <p>Knowledge of mental health/illness?</p> <p>The way they talk about mental illness?</p> <p>Relationships?</p> <p>With you?</p> <p>With others?</p> <p>Home life in general?</p> <p>School life?</p> <p>Wellbeing?</p> <p>The state of being comfortable, happy and feeling okay about yourself.</p> <p>Behaviour?</p> <p>Resilience?</p> <p>The ability to deal with difficult situations and cope in hard times.</p> <p>Self concept</p> <p>How you think and feel about yourself and how you feel others perceive you.</p>	<p>Can you explain?</p> <p>Can you give an example?</p>

		Any other impact?	
Perception and understanding of support in schools / elsewhere?	Did you have a link person between school and Kidstime?	<p>How did you come to meet this person?</p> <p>Did you find it helpful to have a link person?</p> <p>If so, how did this help you?</p> <p>Do you still have contact with this person now?</p> <p>does it help?</p>	
	Do you think anything would be different if Kidstime referrals came through mental health services rather than through school?	<p>What would be different?</p> <p>What do you feel would be the advantages and disadvantages of this?</p> <p>Are you/your child involved with mental health services currently?</p>	
	Do you know of any extra support that your child receives in school?	<p>What is it?</p> <p>Do school understand your family and your needs?</p> <p>Do you think it is important that school understand your family situation with regard to your mental health needs?</p> <p>Why?</p>	Can you tell me more about what happens?
	Do you think it is important that school know about your mental health needs?	<p>Why do you think that?</p> <p>Are you in regular contact with the school with regards to your needs and the needs of your child? With who? In what way?</p>	

	Is there any other support that you know of that you think your child needs?	What is it that you feel your child might need support with/for?	Can you explain why?
	Is there any other support that you feel you might need as a family or for you as an individual?	What kind of support do you feel you / your family need?	Tell me more about that.
Is there anything else you would like to discuss?			

Interview schedule for facilitators of Kidstime workshops

Issue/topic	Questions	Possible follow-up questions	Probes
How does Kidstime in Southbridge correspond with the aims stated by the Kidstime foundation?	What would you say are the main aims of Kidstime?		
	How do you think facilitators promote the aims of Kidstime?		
	Is there anything that you feel gets in the way of the fulfilment of the aims of Kidstime?	How do you manage that?	
Perception of the elements of Kidstime	What do you feel is the purpose of...	<p>The Seminar</p> <p>The individual groups for adults? Children?</p> <p>Coming together at the end of the Kidstime session?</p>	In your opinion, how successful is this part?
Impact of Kidstime	What impact do you think Kidstime has on the families that attend?	<p>In relation to...</p> <p>The children?</p> <p>The parents with mental health needs?</p> <p>Other family members that attend?</p>	Have you any examples of this impact that you have noticed?
	Do you receive any feedback from schools/other professionals in relation to any impact of Kidstime	What is the nature of this feedback?	

	on the children/parents attending?		
School-linked referral system	How would you describe the benefits of having a school-linked referral system?	Do you feel there are advantages/disadvantages of the school-linked referral system as it operates here in 'Southbridge'?	
	How would you describe the disadvantages to a school-linked referral system?		
	What are your thoughts on the health-based referral systems operating elsewhere?	What do you see as the possible advantages and disadvantages of a health-based referral system?	
	Can you think of anything you would change in relation to referral systems for Kidstime?	What would the benefits be of this change?	
	What else do you feel could be done to increase the availability and awareness of Kidstime? –		

Perception and understanding of support in schools / elsewhere?	To your knowledge, are there any other local support services available to children of parents with mental health needs?	What is the nature of this support?	
	Could you describe any support available for children of parents with mental health needs in schools that you are aware of?	Do you feel school staff have an awareness / accurate understanding of the needs of these children? If not, do you have any thoughts on how this might be improved?	
	What support do you feel could be put in place in schools to support children of parents with mental health needs?	What might this look like? How would this be helpful?	
	What do you feel are the barriers to school-based support for COPMHN?		

Is there anything else that you feel is important to mention in relation to Kidstime, its impact, the referral processes or anything else?

Appendix C

Focus group stimulus questions for phase 2a participants (Secondary school children)

Issue/topic	Questions	Possible follow-up questions	Probes
Understanding of mental illness	What is your understanding of mental illness?	(mind map/draw in pairs)	Can you talk me through what you have done?
	Do you know someone with a mental illness?	Can you tell me more about that person/people?	Can you draw/write/say?
	Do you learn about mental illness in school?	If yes...what do you learn? Do you think this is helpful/important?	Why?
Support available	Is there help available for you in school in relation to mental health? Your circumstances?	If yes... what is it? How does it help? If no, what help do you feel is needed?	Prompt young carer support groups
	What might be different if help wasn't available in school?	Where else might you access support?	
Ideas for future support for younger children	Do you remember learning about mental health/mental illness in primary school?	If yes, what can you remember? If no, do you think that would have been helpful or not?	Why?
	Have you got any ideas about how younger children could be taught	What information might they need to know? How else might children who have difficulties at	

	about mental health/illness?	home be supported in school?	
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Is there anything else you would like to mention/discuss?

Appendix D

Interview schedule for Phase 2b participants (SENCOs)

Topics to be discussed	Questions	Possible follow-up questions	Prompts
Current support around mental health generally	Does mental health education happen here in your school?	If so , what form does it take? If not , are there plans to do this?	What is the purpose? Impact?
Knowledge and understanding of needs of children of parents with mental illness (COPMI)	Are you aware of children in your school experiencing parental mental illness?	How did you come to find out about these children? Do you have a member of staff that works closely with families? E.g. PSA? Would they know more about this? What are your thoughts on the effects on children living with parental mental illness?	Can you tell me more about this?
Support for COPMI	Does your school currently offer support for COPMI?	If no... for vulnerable children more generally? If yes - What form does this take? Are there other services that you know of who offer support to these children?	
	Are you aware of the Kidstime workshops?	If no briefly explain intervention and key research findings – link to next questions	

	<p>My research found that explicitly teaching children about mental illness using the correct language might have a positive impact on understanding. Can you see a role for schools to educate children about mental illness?</p> <p>The importance of opportunities to spend time with others in a similar situation, as well as the need for respite and time outside of the family home was also highlighted. Can you think of a way that primary schools could facilitate this?</p> <p>Opportunities to express thoughts and feelings through creative activities was highlighted as important. Do children have the opportunity for this in school?</p> <p>Ongoing stigma around mental illness</p>	<p>How might this happen? (teachers / external agencies / whole school approach)</p> <p>Do teachers currently have awareness/ understanding / training and confidence?</p> <p>What is currently in place in your school?</p> <p>If not, could this be done? What form might this take?</p>	
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	<p>was another theme that came up, including the idea that both adults and children stigmatise mental illness and other needs – do you have any ideas on how schools might begin to address this?</p> <p>Do you see a role for primary school staff in supporting the needs of parents themselves?</p> <p>Is there any other support you feel you would like to see put in place in schools to support the needs of this group of children and their families?</p>	Does your school currently offer support for parents?	
	What do you feel are the barriers to the implementation of support for COPMI in school?	Do you have any ideas about how these barriers could be overcome?	Who could make these changes?
Next steps for support	Do you feel your school could do with additional support and guidance around COPMI?	<p>What are the gaps?</p> <p>What form of support would be helpful?</p> <p>Training?</p> <p>Resources?</p>	What would be helpful?

Is there anything else you would like to discuss in relation to this topic?

Appendix E

Braun & Clarke's (2006) stages of thematic analysis alongside details of my own analysis.

Stages of Thematic Analysis	My Analysis
1.Transcription	<p>I personally transcribed the recorded data from all interviews using Microsoft Word. Although this was a long process, I chose not to use transcription software, as I wanted to immerse myself in the data, and have the opportunity to recognise subtleties in the way the interviewees responded, adding to the richness of the data. During transcription, I typed some notes representing my initial thoughts, using the tracking system on Microsoft Word.</p>
2.Reading and familiarisation	<p>I printed off all the transcripts and read them a number of times, to further familiarise myself with the data. At this stage, I highlighted sections of the text and made hand-written notes based on my thoughts and interpretations on each individual transcript. I re-read each transcript at least three times, each time adding notes and making links within the data. The more I read the transcripts, the more I was able to think on a deeper level about the data, noticing topics and ideas that were not immediately apparent. This process of immersion in the data and re-reading on multiple occasions builds the 'trustworthiness' of my interpretation of the data.</p> <p>I then recorded all my handwritten notes as codes to the tracking system on Microsoft word, so that all my codes were in one place, attached to each transcript.</p> <p>In making my initial notes, I was mindful of my positionality in relation to the data collected, and therefore recognise that these initial notes may have reflected a noticing of topics and subjects that are important to me, or that I might have expected as a researcher. As an interpretivist researcher, I continued to remain</p>

	<p>mindful of my influence on the data throughout analysis, and employed a systematic approach to coding the data, using the text from the transcripts as a starting point for formal analysis, utilising a bottom-up, rather than top-down process, so as to reduce confirmation bias.</p>
3.Coding	<p>I used Microsoft word and the comments function to record all codes against the raw data on each transcript individually. A complete coding approach was used, whereby all data collected was coded (Braun & Clarke, 2013). These codes were predominantly data derived codes, with the codes reflecting a summary of what was explicitly said. There were also some researcher-derived codes that reflect more implicit ideas and sought to understand the assumptions and frameworks that underpin what was explicitly said (Braun & Clarke, 2013). These are codes that reflect my own interpretation of the data, based on patterns and links that I have drawn from the transcript data.</p>
4.Searching for themes	<p>I analysed each group of interviews separately. For phase 1, these groups were: Kidstime children, Kidstime parents and Kidstime facilitators. I generated a number of categories for each group based on the grouping of similar codes. I then combined all of the categories from the three groups to search for common themes.</p> <p>For phase 2a, the year 8 and year 11 focus groups codes were generated based on the individual focus groups. These codes were then combined to create common themes.</p> <p>For phase 2b, the codes generated for each SENCo interview were combined to derive categories and then themes.</p> <p>I combined categories and themes as described above in a separate word document. I used a separate colour for each participant when combining the codes in to one document for analysis, to ensure I could remain mindful of the number of participants making similar comments once all the data was combined. I was eager to ensure that the comments didn't tend to reflect only one person's perspective.</p>

	<p>I felt this approach to analysis allowed more flexibility and creativity than some of the thematic analysis software I have used previously, as I was able to adapt and rearrange themes as I became more familiar with the data. Some themes became apparent during the coding process, so these were often the easiest to bring together. As I grouped similar categories, themes became more apparent.</p>
<p>5. Reviewing themes – map of provisional themes and subthemes</p>	<p>I created maps for individual themes and subthemes, to help visualise the key points for each set of interviews. For phase 1, I brought together the themes from each set of interviews and grouped them under global themes from all of the interviews.</p>
<p>6. Defining and naming themes</p>	<p>The process of identifying codes, then categories and finally themes allowed these themes and categories to be fluid and changeable throughout the process of analysis. Once defined and named, I checked my codes, categories and themes alongside learned research colleagues and my research supervisors, to further add to the trustworthiness of my interpretations.</p>

Appendix F

Examples of handwritten notes alongside raw transcription of data collected from interviews and focus groups.

Phase 1: Interview sample:

** Not sure the link between own mental health & boys' mental health is fully recognised?* Emily Transcription

How did you first find out about Kidstime?

Initially I was introduced to it because my eldest son (name) was self-harming at school, and I had issues with my second oldest son, who is 10, who witnessed domestic abuse, witnessed me being strangled and thrown about and he's not very good at talking and opening up, talking about how he feels, ummm, so to help them deal with their issues, alongside my mental health issues, which started when I was a child, and in to my adulthood.

Recognition of child's emerging needs as being related to own mental health?

Is there a recognition of the relationship?

Okay, so how did you first find out about Kidstime?

I was first introduced by the parent liaison at (name) school and through the EHAT? The CAF meetings. It was done through that and they thought it would be a good way of getting me involved in the (MAST) system to support the kids, because since I left the military in 2016 I've not had any mental health support at all.

multi-agency recognition (have all the info) joined up approach.

Okay, so they recognised that there might be a few different ways that it would help?

Yeah.

Okay, so you said it was through the parent liaison officer. Did you go in to request support or did they come to you?

Schools triggered the referral - would this parent have been left unsupported otherwise?

It was kind of a bit of both. They called me in because of the issues with my eldest self-harming um and after having a chat with her she decided to get the meetings together and it's been ongoing for the last two years these meetings, trying to support the boys.

Why do you come to Kidstime?

connecting/building relationship with others.

I personally come because it's nice to get out and see other people but it's also nice to see what my boys think about mental health. I've got a lot of other physical health issues alongside my mental health and I wasn't aware how much it affected them. Through Kidstime I've been able to see things in their eyes and how they perceive them, which has been interesting as well because I didn't realise they understood as much as they did, even though I try and explain a lot, I didn't realise they had an understanding.

gaining insight on to their perspective

What keeps you coming?

Me and the boys very rarely do anything together or go out. The boys aren't keen on going but once they are there they interact a lot and I think they get something out of it when they go. But it's nice to have time with them.

engagement/connection w/ content

What do you think the boys get out of it when they go?

chance to come together as a family - can mental illness make this hard? other + others?

I think it gives them a voice. A chance to express how they feel and they get chance to be listened to and with my second eldest, he's not very good at expressing things, so when they are doing videos and being artistic, they can explore other mediums without talking and I think that's very good for them.

various mediums to communicate understanding / gain understanding / learn.

You have kind of touched on this already but you may be able to add something.. who do you feel benefits from Kidstime?

Yeah, I think it benefits all three of us in different ways. I get a better understanding of how the kids feel and the kids definitely get a voice and I definitely come away most times with a deeper

chance to have their say / voice opinions / ask questions

bameis?

Phase 2a: Focus group sample:

lack of understanding / empathy

its, they should have a lot more compassion for people. I know they can't always be like, put in special measures, but you've gotta be like... you know bursting out crying is not a good thing for us. we wanna keep it in, we wanna keep controlled, for when we go home we don't wanna think about what's happened at school, you know what I mean, we wanna be ready to crack on with what's going on at home.

collective identity

Darcy - you wanna be a strong person don't you? You don't wanna show anyone you're weak.

as strong & capable. The need to present

Annie did start off more +ve

Annie- yeah and then somebody makes you cry and you think, whats the point anymore? nobody gets it really I don't think.

(is this something that has built up over the years? Could this feeling of lack of trust and unaware professionals be prevented in the future?)

What do other people think about that?

Darcy - I think that's true

probably this (she has to illustrate her feelings)

group int effect?

OR feeling safer to say what she thinks?

Chloe - I'm not sure. I feel like, alone. I feel like if I ever needed to speak to someone about what I go through and how I feel about that, I would be 100% alone. - This does contradict something Chloe said earlier. - maybe she means 'in school'

Darcy - yeah I would. (feel alone)

Chloe - because I remember, I went to speak to a teacher once, and I had had a really hard night with my brother and I got told 'everybody goes through stuff' it doesn't matter... I need to suck it up really.

Has the discussion led Chloe to think of negative experiences?

(one incident can cloud judgement? Reinforced? Failure to then seek help due to expectations)

-ve experiences of professionals

Annie - yeah they compare you to everyone else yet, I know some people obviously care for different people but, when you're at the very bottom of the spectrum, or if you've had a hard night you do not wanna hear that rubbish, like, you can't help what's happened to you. I've been told in sixth form, 'just get on with it', you know 'people go through stuff', 'you should put yourself first', how can I put myself first when I'm the only person in the house with my mum? She's screaming in pain, she can't do anything herself, trying to like overdose on her tablets, how can I put myself first? Because if she does do anything, that's on me, nobody else, that's gonna be on me and that's gonna make me feel like crap.

Huge sense of responsibility

Chloe - I don't think family understand either because my aunts, my uncles... nowhere to be seen when it comes to my brother... what did you say (to Annie) your brothers have left?

family do not und / support

Annie - yeah because when they were younger, like the youngest one is 16 years older than me and my mum wasn't like it and she got like it when I was born, so I've had to grow up with that but my brothers and sisters didn't get anything like that, they had a happy

lack of und from family

Phase 2b: interview sample:

Charlotte Transcription

Does mental health education happen here in your school?

We wouldn't necessarily use the term mental health, but as part of our PSHE curriculum we talk to the children about feelings. I'm a THRIVE practitioner, as are two other members of staff in the school and we have disseminated research and THRIVE practice so everybody understands that sad may be a physical feeling and we are increasingly trying to, when we are working with children and they are telling us they are sad... asking 'but what does sad mean?' Unpicking it a little bit. Asking 'how does your body feel when you are sad?' and actually recognition that you can be sad in different ways. So working with particular children who might be going to CAMHS, we have been doing some work on size of feelings, so being a little bit sad or a lot sad. We also have mindfulness in every class twice a day and we talk about using it to 'give your brain a rest' and also that we can use mindfulness when our brain is feeling too busy.

staff discuss feelings whole school approach

additional training school staff might not use terms explicitly. aspects of PSHE cur. allow for emotion focus. staff work with children to talk about feelings

focus on mental health mindfulness practices.

So, you are focusing on the negative feelings as well as the positive then?

Yes, we are unpicking some difficult feelings. And we did the 'place 2 be' for children's mental health week before half term and if you look on our website, our newsletter is on there so every class, it was a chance to revisit feelings, it was a chance to remind staff of the training they have had, and about the positive benefits of using the outside space and talking about feelings in the outside space... so saying to children, do you prefer doing your maths in the inside space or the outside space? Why is outside better? Then we sent home a place 2 be top five tips for parents in supporting children with their mental health. It's a whole school thing, it's part of PSHE, it's part of mindfulness.

mental health topics revisited to remind staff & children

engaging with families in relation to mental health topics.

whole school approach, embedded in curriculum?

What kind of impact do you think that has on the children?

It's slow, it always is, but children are able to talk about their feelings and the children who have the more difficult emotions and the 'bigger' feelings, are able to start using scaling to talk about it. I had a child that came to me the other day and said I tried this the other day and it did help (the mindfulness activities). Quite a common phrase that myself and the other SENCo use is 'it's okay to be angry, it's okay to be worried, but it's not okay to kick other people when you're angry. What can we do with that instead? Sorry the other thing I should mention in relation to the mental health is that we are an ACE lens school, so it's like a trauma informed school, so we have done a lot of research on ACEs and their impact on children but we have also done research on the fact that the parents of the children we are working with are also subject to ACEs and actually the whole familial pattern, where if that parent has ACEs in their life, that is changing how they are interacting with is because of the impact on their mental health.

slow impact

children talking about understanding feelings

school recognise family links regarding ACEs. (holistic approach)

When children start our school, we have a pre-school interview with the parents and basically start making it clear to those parents that we do ask the difficult questions, so... is there any substance abuse in your family? Has there been any recent bereavement? So we ask them questions around ACEs at the start.

additional training school has a focus on ACEs.

School open & honest with parents from outset.

That is such a good idea!

Does this school have more training/ focus/ enthusiasm for this topic!?

Appendix G

Initial codes alongside transcripts

Phase 1: Sample from interviews (child attending Kidstime)

Tell me about what you have brought with you?	Ford, Danielle Code: child understands that mental health is something you feel inside
I was asked to, well like mental health is like normally what you feel inside, so Luke said do something like to represent mental health. So, I did a mask with one side normal of what you would feel like people would see and what you would show and a side where you don't feel what you show.	Ford, Danielle Code: opportunities to create artwork to represent mental health issues
Okay so do you mean that what you feel on the inside might be different to what people see on the outside?	
Yeah.	
So tell me how the two halves are different.	Ford, Danielle Code: child has an understanding that people might hide mental health problems
Umm so basically I used normal make up to do this, I did a normal side to show what you would normally show and then I did where you would feel very horrible and distraught inside. So if you cry the mascara smudges everywhere and you have a hole in your head because you would find that mental health is damaging you so much you would find holes everywhere.	Ford, Danielle Code: child finds it easier to discuss mental health and illness via this visual representation, rather than through explanation below
I think that mask is amazing... I really like that.	Ford, Danielle Code: recognition of the impact of mental illness on someone
So I want to ask now about the impact of Kidstime... so whether or not anything has changed for you since coming to Kidstime.	
Has your knowledge and understanding of mental illness changed?	Ford, Danielle Code: child has more information about mental illness
For me, I've got more information about mental illness and what it is about. I can help mum more now because I understand.	Ford, Danielle Code: child feels more supportive of parent due to understanding
If someone came along and they had no idea about mental illness, how would you explain it to them?	Ford, Danielle Code: understanding of some of the thoughts and feelings

Phase 2a: Sample from focus groups (Year 11 focus group)

Beth – not so much about being a young carer but about everything else, yeah	Ford, Danielle Even people there to support do not understand.
Chloe – Yeah, I'd agree with that, I think emotionally I could speak to any teacher here because they understand, they are trained to understand, but I feel like even the lady that runs young carers, they don't understand.	Ford, Danielle Previous experiences of a lack of responsiveness to requests for support.
Annie – as well like, I went to a school before this, and they were honestly shocking, like they didn't have a group or and then like you would ask to speak to somebody throughout the day and they'd be like 'ah yeah we'll get somebody to come and speak to you, 5 days later I'm still asking, like obviously when you're at school you don't wanna go to lessons, you don't wanna do any work because you're thinking about something else	Ford, Danielle Worries relating to being a young carer impact on ability to do school work.
Darcy – they always say as well, like if you're thinking about something or you've been through so much, they say 'go to lesson, it will take your mind off it', but when you're in lesson you're thinking about it 24/7, you're not listening to what anyone is saying anyway so why be in the lesson, and literally every teacher says that 'just go to lesson'.	Ford, Danielle Worries relating to being a young carer affect ability to do school work.
Chloe – they are trained to educate us, but they're not trained to support us because at the end of the day they'll tell us to go to lessons, take our mind off of it, to come back after the lesson, but your head is in such a bad space, you don't, no matter what you go to, you couldn't take that in, but they don't understand. They think that lessons will help us take our mind off of it but if you think about it in this way, we've got all of this pressure from home, we've got to take in all this new education, that we know we have to know for our GCSEs...	Ford, Danielle Teachers do not understand how much worries relating to being a young carer can affect ability to access lessons.
Darcy – it's stressful...	Ford, Danielle Lack of training for teachers in emotional support.
Chloe – It kind of just stresses you because you're having to learn this, but you can't think straight and then you kind of get yourself in to a mindset that 'right if I can't learn this,	Ford, Danielle Teacher's don't understand the impact of worries relating to being a young carer.
	Ford, Danielle Teachers do not understand all of the worries that young carers have and how this affects them.
	Ford, Danielle Collective 'we'
	Ford, Danielle Collective 'we'
	Ford, Danielle It is stressful thinking about school work and the future – it becomes a negative spiral of thinking.

Phase 2b: Sample from interviews (SENCo)

<p>No I don't think they have any clue. I think for the majority of those parents, like 75%, they think they are protecting their children, but they're not really that capable of doing that protective stuff. Children are really savvy as well, they know what's going on and because some of these parents have always had these issues, they're children are just used to it as well and they think they are protecting their children but they are not really. We've got one family, where mum went through something really traumatic, children possibly witnessed it, possibly didn't, we don't really know, and took the counselling for herself but never had the counselling for her children, so now, six, seven years on, the children are struggling, because she hasn't protected them enough and they know a lot. When they joined us mum was really clear... this is what's happened to me and my children, and sometimes, for those boys, school is the safe place so they don't want to talk about it at school and naval welfare threw counselling at them but they weren't ready to talk and we've got to be really careful about that as well. Just because we know someone has got that mental health issue or been through that trauma, actually those children might not be ready for that, and they might not ever be ready. Those boys have had all sorts of counselling, and Kidstime stuff, but never, we don't really know if they know what's happened, so it's a really tricky situation with that one.</p>	<p>Ford, Danielle Some parents do not have the capacity to properly protect their children</p> <p>Ford, Danielle Children have an awareness about mental health needs in their families</p> <p>Ford, Danielle Some children are not protected enough from negative life events</p> <p>Ford, Danielle Some children don't want to talk about issues at school because it's a safe place</p> <p>Ford, Danielle Individual approach to support – children have to be ready</p> <p>Ford, Danielle Sometimes hard to discuss topics with children when there is a lack of knowledge and their situation and experiences</p>
<p>How do you find talking about some of those more difficult issues?</p> <p>It is awkward, it's kind of got to come up naturally in conversation, there is no way I would ever say to a parent "so have you got mental health issues?", but you can ask different questions to get around that, there are questions I ask, like "how much support do you get at home" and they will say "oh I get support from a mental health nurse" and you are like ah okay. There are ways around it, I think people who genuinely have those problems won't say... "well actually yes".</p>	<p>Ford, Danielle Discussing mental health needs can be awkward, you can't be too direct</p> <p>Ford, Danielle Staff skilled at asking questions in more subtle ways</p> <p>Ford, Danielle People with mental health needs might find it hard to talk about them</p>
<p>And then I suppose it is down to someone like you to have those conversations in the first place isn't it, and feel comfortable to ask some of those subtle questions.</p> <p>And that's really hard, and our PSA isn't trained to do all of that, they've got to open up, and that's really hard for someone with a mental illness.</p>	<p>Ford, Danielle PSA is not trained to deal with some of the issues around mental health needs</p> <p>Ford, Danielle Mental illness makes it hard for people to open up</p>

Appendix H

Grouping of codes into categories and subsequent grouping of categories into global themes

**Below is a sample from Kidstime facilitator interviews of how codes formed categories, and how categories formed themes.*

Below is an example of how the global theme: Impact on families* was derived based on the facilitator interviews.

The codes (coloured and underlined) below were grouped together to form categories (in black, bold font). The different colours for codes represent different participants' comments.

Categories were then grouped together alongside categories from other groups of interviews (children and parent interviews) and conceptualised under the global theme of: Impact of Kidstime on families.

All global themes discussed in the research were derived in this way.

Theme: Impact on families (colours represent individual participant responses).

Codes	Categories
<u>The impact of Kidstime can take a while to be seen</u> <u>The fact that most families show up most weeks means there must be some impact</u> <u>Most children want to be there ... so there must be a positive impact</u> <u>Sometimes children aren't aware they are 'getting it'</u> <u>Other family members can positively share the experiences and learning even when sessions are difficult, there is always some progress to be seen</u> <u>important, valuable moments even in chaotic sessions</u> <u>There has been positive feedback from schools about the impact of Kidstime of the children/families that attend</u> <u>Long-term approach</u> <u>Progress and advances happen over a long period of time</u> <u>The impact on families is mixed and has its ups and downs, but its overall positivity is obvious</u> <u>Sometimes you can see an impact from the beginning to the end of one session</u> <u>Can recognise a huge impact on families</u>	General impact on families

<p><u>Some families attend for long periods and express they can't manage without it</u></p> <p><u>Hard to say the impact on children, it can appear they don't get it</u></p> <p><u>Some of the creative activities give the children a chance to be children</u></p> <p><u>KT has a huge impact on parents that attend</u></p> <p><u>Parents rely on KT staff quite heavily</u></p> <p><u>KT families can depend on KT staff for support</u></p> <p><u>Families would say there is nothing else like KT</u></p> <p><u>Families express that they need KT for support</u></p> <p><u>Other family members attending is generally supportive for the family</u></p> <p><u>Some people leave KT as they feel they have been given the skills and tools at KT and can apply them independently</u></p> <p><u>Not a lot of feedback from schools about an impact on children in school</u></p> <p><u>KT staff receive communication from families in crisis between sessions, because they have no one else</u></p> <p><u>Families get a lot out of KT</u></p> <p><u>Positive to recognise when families no longer rely on the intervention</u></p> <p><u>The impact of KT is not always in the sessions</u></p> <p><u>Impact can take a long time to be seen</u></p> <p><u>Progress is slow and learning is not always permanent</u></p> <p><u>Progress can be difficult to quantify</u></p> <p><u>Often hard to see the impact as a facilitator</u></p> <p><u>Sometimes progress can be undone due to deterioration of parent's mental health</u></p>	
<p><u>Kidstime helps parents recognise the impact of the mental illness on relationships.</u></p> <p><u>Kidstime helps the parents recognise how they affect their children which can be humbling</u></p> <p><u>Kidstime can help families to be more integrated</u></p> <p><u>Kidstime can help families to be more independent</u></p> <p><u>Families have taken on board some of the processes explored in Kidstime in their everyday lives</u></p> <p><u>Parents report positive effects on family life</u></p> <p><u>Parents report gaining the ability to understand and explain together the effect of mental illness on family life</u></p> <p><u>Kidstime allows families to feel more confident to be together</u></p> <p><u>Families have been seen to take on board strategies demonstrated in KT sessions in their own lives</u></p>	<p>Family relationships and functioning</p>
<p><u>Social opportunities at Kidstime can reduce isolation</u></p>	<p>Social relationships /</p>

<p><u>Kidstime provides opportunities for families to connect with other families in similar situations</u></p> <p><u>Kidstime allows attendees to recognise universality of mental illness</u></p> <p><u>Families tend to integrate more with the group as time goes on</u></p> <p><u>When families integrate within the group more, that is when you can notice an impact</u></p> <p><u>The first impact is often when families start communicating with each other and feeling less alone and less stigmatised</u></p> <p><u>Kidstime provides some attendees with a sense of being able to help and support others in the group due to lived experienced and knowledge about mental illness</u></p> <p><u>Kidstime allows families to realise they are not the only ones going through this experience</u></p> <p><u>Helps children to realise they are not the only ones experiencing parental mental illness</u></p> <p><u>Kidstime has built trust for adults in some children</u></p> <p><u>KT promotes the development of new friendships</u></p> <p><u>Some children might attend KT for social opportunities</u></p> <p><u>Parents will often turn to KT staff with difficulties before anyone else – trusting relationships</u></p> <p><u>KT provides families with a sense of belonging</u></p> <p><u>Isolation is reduced for families as a result of KT</u></p> <p><u>KT provides an opportunity to families to be alongside others in similar positions</u></p>	<p>feelings of reduced isolation / sense of belonging</p>
<p><u>Parents are able to communicate with their children in a more positive way than previously</u></p> <p><u>Kidstime helps families to learn how to communicate</u></p> <p><u>Kidstime can help families to communicate more positively</u></p> <p><u>Other family members' attendance can be a help or a hindrance</u></p> <p><u>Other family members can positively share the experiences and learning</u></p> <p><u>Other family members attending can promote consistent knowledge and messages for the child regarding mental illness.</u></p> <p><u>Kidstime encourages discussions and open communication about mental illness</u></p> <p><u>Parents report gaining the ability to understand and explain together the effect of mental illness on family life</u></p> <p><u>Kidstime allows families to talk more</u></p> <p><u>Kidstime allows families to adopt the language of mental illness to talk openly</u></p>	<p>Family communication</p>

<p><u>Kidstime helps to raise awareness of their mental illness, its affect on them, and on their children</u></p> <p><u>Kidstime helps parents be more mindful about the language they use</u></p> <p><u>It can take months and months or longer for parents to recognise the impact of their mental illness on their children</u></p> <p><u>Kidstime can help families better understand what is happening for them.</u></p> <p><u>Other family members can positively share the experiences and learning</u></p> <p><u>Other family members attending can promote consistent knowledge and messages for the child regarding mental illness.</u></p> <p><u>Kidstime gives families alternative perspectives to viewing situations and mental illness.</u></p> <p><u>Role plays and films made by children give parents insight in to children's perceptions of mental illness</u></p> <p><u>Kidstime gives children a more concrete understanding of mental illness</u></p> <p><u>Kidstime helps to address the myths surrounding mental illness and gives children the facts</u></p> <p><u>Labelling mental illness and explaining it makes it less frightening for children</u></p> <p><u>Importance of a shared narrative around mental health and illness</u></p> <p><u>Kidstime helps parents realise the impact of their mental illness on their children</u></p> <p><u>Kidstime helps parents to realise how much their child understands about their mental illness</u></p> <p><u>Kidstime provides an opportunity for the parent to gain insight in to the child's insight</u></p> <p><u>Parents are given an opportunity to see how children understand their parent's mental illness</u></p> <p><u>Kidstime provides explanations about mental illness</u></p> <p><u>Kidstime provides families with the language to talk about and explain mental illness</u></p> <p><u>Parents report gaining the ability to understand and explain together the effect of mental illness on family life</u></p> <p><u>KT can help support children's understanding of typical feelings and those associated with mental illness</u></p> <p><u>KT can help children understand the connections between their own mental health and their parent's mental health</u></p> <p><u>The older children have a better understanding</u></p> <p><u>Parents who are explicit with their children about their mental illness really get it</u></p> <p><u>KT can help support other family members to better understand how to support the parent with mental illness</u></p>	<p>Understanding</p>
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<p><u>KT gives other family members a sense of what it might be like to have a mental illness</u></p> <p><u>KT can give other family members insight in to the lived experience of parent with mental illness</u></p> <p><u>KT helps people recognise the impact their mental illness has on their behaviour</u></p> <p><u>KT helps parents with mental illness understand why they behave in a certain way</u></p> <p><u>KT can suggest answers and give clarity about behaviour associated with mental illness</u></p> <p><u>The parents tend to underestimate the children's understanding</u></p> <p><u>parents gain insight in to child's understanding as a result of feedback from individual groups</u></p> <p><u>Families show a greater insight in to their mental illness</u></p> <p><u>Adults group can help parents better understand their children's behaviour</u></p> <p><u>KT provides children with a different narrative around some of their behaviour and experiences</u></p> <p><u>KT facilitators can provide children with different experiences than they might get at home</u></p> <p><u>KT can enable families to better understand how MI affects their behaviour and the children</u></p> <p><u>KT gives parents insight in to themselves</u></p>	
<p><u>Kidstime helps parents be more mindful about the language they use</u></p> <p><u>Children begin to demonstrate an impact when they are able to express themselves through art / metaphor in sessions, even if they don't realise it.</u></p> <p><u>Other family members attending can promote consistent knowledge and messages for the child regarding mental illness.</u></p> <p><u>Being transparent about mental illness spreads to others, allowing people to talk more openly</u></p> <p><u>Kidstime gives children the language to discuss mental illness</u></p> <p><u>Kidstime provides a place for children to explore their feelings</u></p> <p><u>Kidstime encourages discussions and open communication about mental illness</u></p> <p><u>Creative activities at Kidstime allow children to explore some of the issues</u></p> <p><u>Kidstime provides families with the language to talk about and explain mental illness</u></p> <p><u>Parents report gaining the ability to understand and explain together the effect of mental illness on family life</u></p> <p><u>Kidstime allows families to talk more</u></p> <p><u>Kidstime allows families to adopt the language of mental illness to talk openly</u></p>	<p>Language and expression</p>

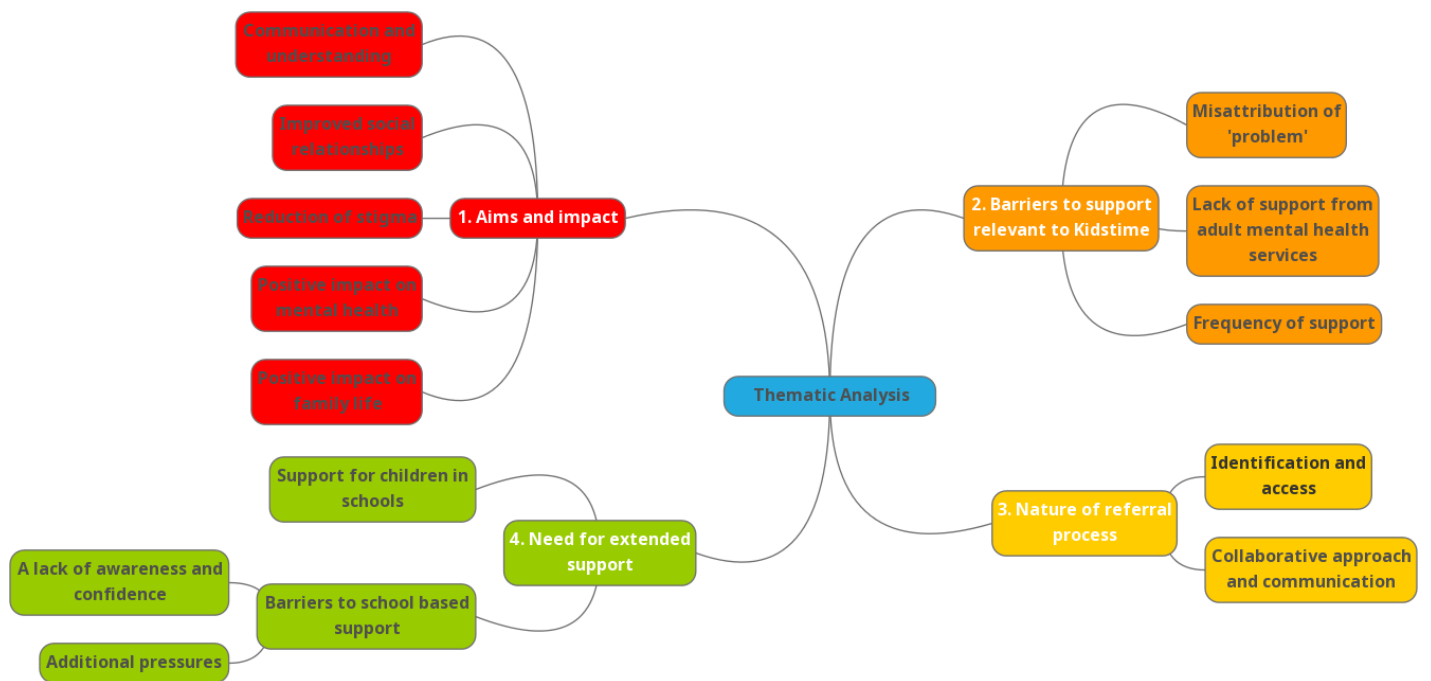
<p><u>Some children at Kidstime demonstrate expression of their thoughts and feelings</u></p> <p><u>Children can express themselves through creative activities</u></p> <p><u>Kidstime gives children permission to be creative and have their creations valued</u></p> <p><u>Children afforded creative freedom in Kidstime sessions</u></p> <p><u>Children given a sense of responsibility in guiding sessions with their ideas</u></p> <p><u>Children can repeat words associated with mental illness</u></p> <p><u>Some of the creative activities give the children a chance to be children</u></p> <p><u>Some of the children display difficult behaviour, which may be an expression related to home situation</u></p> <p><u>Parents who are explicit with their children about their mental illness really get it</u></p> <p><u>Parents communicate with KT staff between sessions to express difficulties</u></p> <p><u>Sometimes the direct use of language is challenging for parents but KT is about talking openly</u></p> <p><u>The children's sessions give them an opportunity to express their own experiences</u></p> <p><u>adult group provides opportunities for expressing and discussing own thoughts and feelings</u></p> <p><u>KT facilitates discussions on topics that attendees may never have had before</u></p>	
<p><u>Kidstime helps to remove some of the stigma associated with mental illness</u></p> <p><u>The first impact is often when families start communicating with each other and feeling less alone and less stigmatised</u></p> <p><u>The sense of privacy at KT may be what builds a sense of trust for some families</u></p> <p><u>Still a stigma around mental illness meaning KT still private</u></p> <p><u>Private side to Kidstime</u></p> <p><u>Not many people know about Kidstime and its not discussed much in schools</u></p> <p><u>Conversations about MI partly de-stigmatises it</u></p> <p><u>Naming MI and talking openly helps to destigmatise</u></p>	Addressing stigma
<p><u>Kidstime can help families to be more calm</u></p> <p><u>Kidstime can help individuals/families to feel less anxious</u></p> <p><u>It is a support for families to know that Kidstime is available if needed</u></p> <p><u>Kidstime provides families with someone to talk to</u></p> <p><u>Impact of Kidstime seen on children in school – appearing more settled</u></p>	Mental health

<p><u>Feedback from schools regarding parents needing less in-school support as a result of Kidstime</u></p> <p><u>Kidstime provides a place for children to explore their feelings</u></p> <p><u>Kidstime has built confidence in some children</u></p> <p><u>KT can help children understand the connections between their own mental health and their parent's mental health</u></p> <p><u>KT can provide time where children don't need to worry about their parents</u></p> <p><u>KT provides the opportunity to talk to someone</u></p> <p><u>KT provides a safe place</u></p> <p><u>the adult group provides an opportunity for them to offload</u></p>	
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Appendix I

Exemplar thematic map

Below is an example of the global themes and subthemes from the Kidstime interviews with children, parents and facilitators represented in a thematic map.



Appendix J

Approved ethics proposal and certificate of ethical approval

Ethics Proposal:



COLLEGE OF SOCIAL SCIENCES AND INTERNATIONAL STUDIES

When completing this form please remember that the purpose of the document is to clearly explain the ethical considerations of the research being undertaken. As a generic form it has been constructed to cover a wide-range of different projects so some sections may not seem relevant to you. Please include the information which addresses any ethical considerations for your particular project which will be needed by the SSIS Ethics Committee to approve your proposal.

Guidance on all aspects of the SSIS Ethics application process can be found on the SSIS intranet:

<https://intranet.exeter.ac.uk/socialsciences/staff/research/researchenvironmentandpolicies/ethics/>

All staff and postdoctoral students within SSIS should use this form to apply for ethical approval and then send it to one of the following email addresses:

ssis-ethics@exeter.ac.uk This email should be used by staff and postdoctoral students in Egenis, the Institute for Arab and Islamic Studies, Law, Politics, the Strategy & Security Institute, and Sociology, Philosophy, Anthropology.

gseethics@exeter.ac.uk This email should be used by staff and postdoctoral students in the Graduate School of Education.

Ref (for office use only)

201718-135

Applicant details

Name : Danielle Ford

Department : DEdPsych

UoE email address : xxxxxx

Duration for which permission is required

You should request approval for the entire period of your research activity. The start date should be at least one month from the date that you submit this form. Students should use the anticipated date of completion of their course as the end date of their work. Please note that retrospective ethical approval will never be given.

Start date: 09/05/2018

End date: 01/09/2019

Date submitted: 05/2018

Students only:

All students must discuss their research intentions with their supervisor / tutor prior to submitting an application for ethical approval. The discussion may be face to face or via email.

Prior to submitting your application in its final form to the SSIS Ethics Committee it should be approved by your first and second supervisor / dissertation supervisor/tutor. You should submit evidence of their approval with your application, e.g. a copy of their email approval.

Student number: xxxxxxxx

Programme of study: Doctor of Educational Psychology (DEdPsych)

Name of Supervisor(s)/tutors or Dissertation Tutor: Shirley Larkin, Caroline Gallagher

Have you attended any ethics training that is available to students?
For example, the Research Integrity Ethics and Governance workshop:
<http://as.exeter.ac.uk/rdp/postgraduateresearchers>

Yes, I have taken part in ethics training at the University of Exeter

If yes, please give the date of the training: 19/01/2018

Certification for all submissions

I hereby certify that I will abide by the details given in this application and that I undertake in my research to respect the dignity and privacy of those participating in this research. I confirm that if my research should change radically I will complete a further ethics proposal form.
Danielle Ford

Double click this box to confirm certification ☒

Submission of this ethics proposal form confirms your acceptance of the above.

TITLE OF YOUR PROJECT

An exploration of the impact of Kidstime and of parental mental health awareness and support in schools.

SYNOPSIS OF THE RESEARCH PROJECT

The intergenerational persistence of mental health problems is strongly supported by the literature. Children of parents with mental health needs (COPMHN) are at risk of developing a mental illness themselves, and risk a number of other negative outcomes. These children are considered to be experiencing at least one of the top ten adverse childhood experiences (ACE), known to significantly reduce their life chances and opportunities. The UK government is

placing increasing emphasis on the need to make mental health support available to children in schools, however the ever-growing strain on children's mental health services means that children in need are not often receiving the support in a timely manner. It is therefore important that other support services can explore ways to provide this support, not only in response to presenting needs, but also early intervention support services for groups known to be vulnerable.

Kidstime is an intervention for children of parents with mental health needs. Kidstime involves workshops for children and parents. The main aim of Kidstime is to increase understanding in relation to mental health. The Kidstime workshops aim to; Promote resilience in the children who are affected by parental mental illness, promote positive attitudes to mental health for affected young people, work to reduce the stigma associated with mental ill-health in general, and with children of "sufferers" and work to reduce the burden of emotional overload in vulnerable families (Ourtime Foundation, 2017).

Kidstime usually operates a health-based referral system, whereby families appropriate for the intervention are linked in to mental health support services.

In one local authority in the UK, Kidstime operates through a school-based referral system. It is anticipated that this could improve collaboration between schools and relevant support services and widens the understanding and impact of support for this vulnerable group of children.

The proposed study seeks to;

1. Explore 'Kidstime' from the perspectives of the families and facilitators involved – what is the impact and how does this fit with the aims of Kidstime?
2. To explore the knowledge, understanding and perceptions of school staff in relation to children of parents with mental health needs and support available.
3. To develop ideas to support primary schools to support children of parents with mental health needs.

What is involved:

The study will take place from May 1st 2018. Beginning with phase 1. Phase 2 data collection may overlap with data collection in Phase 1. Data will be collected by trainee Educational Psychologist Danielle Ford, under the supervision of Shirley Larkin and Caroline Gallagher.

Part 1: Approximately 5 children attending the Kidstime sessions will take part in a semi-structured interview, including 'draw and talk' activities to act as stimuli for discussion. Questions/activities will focus on the activities experienced in Kidstime and the impact of Kidstime on various aspects of their lives including; wellbeing, self-concept, resilience, relationships, home life and school life.

Approximately 5 parents attending the Kidstime sessions will take part in a semi-structured interview, following the same general themes as above (without school being included). Approximately 8 facilitators of Kidstime will take part in semi-structured interviews relating to the intended and actual impact of particular activities/sessions and the benefits and limitations of the school-based referral system. These facilitators may include Educational Psychologists, family support workers, learning mentors, art-therapists and psychotherapists.

Part 2a: Ideas for future support will be developed alongside secondary school pupils of parents with a mental health need, who have been involved in the 'who cares?' project,

developed by The Ourtime Foundation. Approximately 5 of these children will attend focus groups to help plan next steps for future support.

Part 2b: Approximately 5 Special Educational Needs Coordinators (SENCOs) and teachers will take part in interviews exploring their knowledge and understanding of children of parents with mental health needs, their knowledge of the Kidstime intervention and their knowledge of relevant approaches and support available for these children both in school and outside of school.

Input from the focus groups, the information derived from phase 1 relating to the elements of Kidstime that have a positive impact as perceived by participants and facilitators, and the information from SENCOs in phase 2a will be drawn together by the researcher to contribute to ideas for future support.

RESEARCH METHODS

Part 1

The data will be collected via the semi-structured interviews using the hierarchical focusing model. This model allows the researcher to determine the general direction of questioning whilst giving space for the interviewee's perspective (Tomlinson, 1989). The five stages of this model involve; outlining the structure and content of the research domain, identifying a research focus, devising a hierarchical framework for the interview, carrying out the interview in an open-ended, non-directive way using the interviewee's voice and finally transcribing and analysing. The interviews will be audio recorded. Audio recordings will be used to ensure accuracy and allow for transcription. These transcriptions will then be analysed qualitatively, using thematic analysis.

Approximately 5 children will take part in a semi-structured interview and creative activities to act as stimuli for discussion. Questions/activities will focus on the activities experienced in Kidstime and the impact of Kidstime on various aspects of their lives including; wellbeing, self-concept, resilience, relationships, home life and school. The interview will also include a structured dialogue around the art work and film that the children have created in the Kidstime sessions. This dialogue will involve open-ended questions about the task children were set in order to complete the art work and what they believe the art work shows/represents.

Children aged 5-6 will take part in a simplified version of the semi-structured interview. Further details of this are included in the assessment of possible harm section and proposed questions are included at the bottom of this document.

Approximately 5 parents will take part in a semi-structured interview, following the same general themes as above. Approximately 8 facilitators of Kidstime will take part in semi-structured interviews relating to the intended and actual impact of particular activities/sessions, how this is perceived and measured, and the benefits and limitations of the school-based referral system.

Part 2a

Ideas for future support will be explored via focus groups based on the views and experiences of approximately 5 secondary school-aged pupils (all of whom are COPHMN) attending the 'Who Cares?' project at a local community college. The focus group will aim to understand the needs and wants of this group and the support they receive in school in relation to their parent

experiencing mental health needs. Ideas arising in these focus groups will help to inform the planning of future support.

Part 2b

Approximately 5 Special Educational Needs Coordinators (SENCOs) and teachers will take part in semi-structured interviews exploring their knowledge and understanding of children of parents with mental health needs, their knowledge of and views on the Kidstime intervention and their knowledge of relevant mental health education approaches and other support available for these children both in school and outside of school as well as their thoughts on mental health education in schools and perceived gaps in provision for these children.

PARTICIPANTS

Part 1

All children (aged 5 -12 years) attending Kidstime sessions will be given the opportunity to participate in semi-structured interviews relating to their Kidstime experience. Parents of all children will receive a letter explaining the research and will be given the opportunity to give their consent for their child/children to take part. If parental consent is given, these children will be provided with information about the research in a child-friendly and age appropriate way and will be asked if they are willing to participate.

These children will be informed of their rights as participants. The way in which this will be done is explained in more detail below, in the assessment of possible harm section. Up to 10 children will be interviewed for this part of the research. In order to address confidentiality and anonymity issues when recruiting participants in this way I will ensure that I speak to prospective participants one to one to explain more about the project. I will talk to them about the level of anonymity they want in relation to taking part in the project and negotiate appropriate measures. For example; conducting interviews off site at a mutually convenient location or at a specific time of the participant's choosing.

Approximately 5 parents regularly attending Kidstime sessions will be selected via opportunity sampling to participate in semi-structured interviews. For the purposes of this research, regular attendance will be recognised as attendance at 3 or more sessions within a 3 month period.

Up to 8 facilitators of Kidstime will be selected via opportunity sampling to take part in a semi-structured interview relating to the intended and actual impact of particular activities/sessions, how this is perceived and measured, and the benefits and limitations of the school-based referral system.

Part 2

2a. For the focus groups, children (approximately 5) will be recruited from the "Who Cares?" project, running at a local, mainstream community college. This will happen in the same way as the children from the Kidstime workshops. The facilitator of the local 'Who Cares?' project will be provided with information by the researcher about the research. If the facilitator is willing to be involved in the research, parental consent will be sought for appropriate children, and then children will be approached to give them more information about the research and to ask them if they would be willing to participate.

2b. Special Educational Needs Coordinators (SENCo)s and teachers from schools across the city (approximately 5) will be selected to take part in a semi-structured interview. SENCo)s will be contacted by the researcher, through the link Educational Psychologists within the Southbridge Psychology Service. SENCo)s will be provided with information about the research and will be given the opportunity to discuss this further if needed. Of those who express an interest to participate, 10 will be selected to take part.

THE VOLUNTARY NATURE OF PARTICIPATION

Part 1

Participants will be recruited by the researcher during Kidstime sessions. An information and consent form will be provided to parents and children who are interested in taking part. At the beginning or end of one of the Kidstime sessions, the researcher will briefly explain the nature of the research and offer an information form to any who are interested. They can then look through the information in their own time and make an informed decision. It will also be stated that if any participant (including children) requires help to understand the information, this can be provided by the researcher. Prospective participants will also be told that they can speak with a Kidstime facilitator for more information about the research. Prospective participants will be told explicitly (on the information sheet) that non-participation in the research will not affect the Kidstime attendees in any way and will be reassured of this by the research and facilitators if they express concerns. The researcher will also receive feedback from Kidstime facilitators about their opinions on whether or not particular Kidstime participants are as willing to participate as they may say they are, and will seek to ensure all participants understand their rights as participants. The researcher will also receive feedback from facilitators if they express concerns over the research having a negative impact on particular participants, and seek to address this through sensitive discussion with the participant concerned.

Active consent will be gained from parents, after additional discussions with the researcher if necessary, through the signing of the consent form by both the parent and child. The letter will inform parents that the identity of all participants will be confidential, and that the data will remain anonymous. The letter will explain that Identity will only be revealed if a child protection issue arises. Equally, if the parent discloses information relating to illegal activity or safeguarding, the letter will explain that anonymity cannot be maintained. This is explained in simpler terms in the information form parents will receive. The consent form will also gain consent for the child to be discussed with relevant staff at their child's school (teacher and SENCo), with reference to their referral to Kidstime and subsequent functioning in school (for phase 2).

The beginning of the interview will include an informal discussion with the child about the purpose and nature of the study and they will be told that they do not have to participate if they don't want to. The researcher will ensure (as best as possible) that the child understands the voluntary nature of their participation, explaining that they are free to leave at any time or not take part at all and that this will not affect them in any way. The researcher will remain mindful of the power imbalance in research, and if they feel a participant is uncomfortable with participating, they will offer the opportunity to stop, by reminding them of their rights as participants in an age appropriate way. With the parent and facilitator interviews, there will be a short script reminding them of the voluntary nature of participation, processes around confidentiality and anonymity, the right to withdraw at any time and the right to withdraw data before this data has been made anonymous to the researcher.

Part 2

Participants will be recruited by the researcher through discussion with educational psychologist colleagues linked to schools in the city. Educational Psychologists will be provided with information sheets for SENCos in schools. Participants for the focus groups to develop ideas for future support will be selected from the 'Who Cares?' workshops running at a local mainstream secondary school (community college). This project is run by Ourtime foundation and is aimed at supporting children of parents with mental health needs. Staff involved in the project will be provided with information sheets about the research. Active parental consent will be gained via a consent form, which the children themselves will also be asked to sign if they are willing to take part. The beginning of the focus group will include an informal discussion with the children about the purpose and nature of the study and they will be told and reassured that they do not have to participate if they don't want to, explaining that it will not affect them in any way.

THE INFORMED NATURE OF PARTICIPATION

Part 1

Information about the research will be provided to parents prior to themselves and/or their children completing the interview. Active consent will be gained from parents via the return of a signed consent form attached to the information letter. The letter will inform parents that their child's identity will be confidential, and the data will remain anonymous. Identity will only be revealed if a child protection or safeguarding issue arises.

I will check that children are happy to participate in the research after parental consent has been given, by explaining in child-friendly terms what the research is about and asking them if they are willing to continue. Anonymity, confidentiality and safeguarding will be explained to children via a brief read to each child before the interview / discussion. These topics will be explained to the children in a child-friendly way and children will be asked at regular interviews throughout the discussion if they are happy to continue. I will also ensure that all children are aware of their rights, as outlined below, again in a child-friendly and age-appropriate way. I will explain to children that just because their parent has said they can participate, that it doesn't mean they have to. As much as possible, the researcher will ensure that the participants involved in the research feel they are equal to the researcher, by explaining to the children that their participation is entirely up to them and that they can leave at any time. If children express that they are happy to participate, and this seems genuine, The child will then be asked to sign their name on a consent form.

Written into the beginning of all interviews will be a script detailing information about the nature and purpose of the study. This script will be adapted for children to promote understanding. The researcher will ensure (as best as possible) that all participants understand the voluntary nature of their participation, as well as the processes and procedures in relation to their rights as participants (described previously).

Willingness to participate/Non-verbal signs and cues from children will also be monitored by the researcher, and if there is an indication that the child may be reluctant to engage, or they become less enthusiastic, children will be reminded that they can leave at any time and that this will be respected.

As the researcher has had previous contact with some of the Kidstime participants and facilitators, The researcher will be mindful of the need to remind participants during the interviews and particular sessions of the researchers role within that session and interview, to ensure participants are fully aware.

Interviews/ discussions with the children in relation to this research will take place in a quiet, private room during one of the Kidstime workshop sessions.

Part 2

At the beginning of the interviews, participants will be read a script reminding them of the nature and purposes of the study, as well as reminding them of their rights as participants (described previously).

With regard to the focus groups, information about the research will be provided to parents prior to their children completing the interview. Active consent will be gained from parents via the return of a signed consent form attached to the information letter. The letter will inform parents that their child's identity will be confidential, and the data will remain anonymous. Identity will only be revealed if a child protection or safeguarding issue arises.

Before the focus groups, children will also be reminded of the nature and purpose of the study, alongside a reminder of their rights as research participants. Children in the focus groups will be informed that anything they discuss in the focus groups must be kept confidential

ASSESSMENT OF POSSIBLE HARM

It is important to recognise that this group of participants will be recruited from a small population and hence confidentiality will be even more important to consider at all points of the research including the write-up. This population is also a vulnerable group, particularly some of the younger children and hence I will be continuously mindful of this and will adapt my approach as necessary, handling all aspects of the research sensitively.

I recognise that due to the vulnerable nature of these children and adults, they may be more susceptible to stress that may come about as part of the research process. In order to minimise the risk of harm to participants, I have sought to ensure that questions are carefully worded and do not aim to directly explore difficult experiences and hence participants should not feel they must talk about such experiences. Instead, the questions predominantly focus on the Kidstime workshops and the impact of Kidstime, keeping a distance from deeply personal issues. For all participants, if consent is given, participants will be asked about their wishes regarding anonymity. If a participant is willing to be interviewed within a Kidstime session, a time and quiet space can be negotiated. No aspect of the research will be discussed outside of this room. If a participant would like complete anonymity – e.g. they do not want anyone to know they are taking part at all, or ask questions about why they are going to a different room, then a home visit or different location can be negotiated with the participant, as explained above.

There is a risk of harm to the researcher when conducting interviews in an unfamiliar and unpredictable environment such as in the participant's home. The researcher will ensure their own safety for interviews conducted in family homes by using a 'buddy system', informing someone of their whereabouts, detailing how long they should be, and asking the person to call at a particular time to check in with them. If the researcher does not call back by the agreed time, the 'buddy' will be asked to call a member of the Kidstime staff to check in on the researcher. The researcher will ask the participant prior to a home visit about anything that may pose a risk to the researcher, for example aggressive pets. Ways in which to minimise the risk of harm to the researcher will then be negotiated with the participant.

All interviews will take place in a private room, negotiated with participants, away from the rest of the Kidstime participants to ensure that confidentiality is maintained. In some circumstances, it may be negotiated that interviews will take place at a different location or the family home, depending on what the participant feels would be most appropriate.

Kidstime is an after-school workshop that runs in to the evening, and hence participants who do not want to miss out on any aspect of the Kidstime sessions will not be able to be interviewed immediately before or after due to time and room restrictions. If this is the case, a quiet, private space can be negotiated for the interview to take place. If anyone enters the room in which the participant is being interviewed, the researcher will stop the discussion until privacy resumes.

There is a risk of psychological harm if there is a breach of confidentiality. The participants will be informed that no aspect of the interview will be discussed with anyone else and it will be reiterated that this is an independent piece of research that is unrelated to the Ourtime foundation. As a researcher I will therefore ensure that all audio recordings are handled safely and sensitively and are kept secure. Names of participants will not be mentioned unless a safeguarding issue arises and all documentation referring to the participant will be given a code once transcription is complete. If any safeguarding issues arise as a result of these discussions, this will be dealt with in line with confidentiality protocols, whereby confidentiality must be broken to ensure the safety of the participant. These safeguarding concerns will be reported to the relevant professionals and children will be informed in an age-appropriate way what is happening and why.

I aim to take a number of measures to ensure that all children can participate in the project safely. These measures will be adapted for different ages. During the interview / discussion, If children do not feel confident to voice an answer in response to any question, or simply do not want to, it will be explained that they can use the visuals (smiley faces) to give a response, or they can skip the question. All children will have visuals to enable them to respond the questions without having to say very much if they wish. Younger children (5-6 years) will have a slightly different set of questions in line with their age. Instead of particular questions about elements of Kidstime, younger children will be given the opportunity to complete a picture of their favourite part of Kidstime and discuss their drawing with the researcher if they wish to. The researcher will ensure that research with children takes no longer than 30 minutes (including drawing time for younger children). At the end of the discussion children will be asked if there is anything else in relation to Kidstime that they wish to discuss as part of the research. Children will then be debriefed, thanking them for their time and reminding them of their rights as participants. At this time it will be checked that children are happy with everything that they have said, and they will be given the opportunity to withdraw anything they wish they hadn't said. If any safeguarding issues arise as a result of these discussions, this will be dealt with in line with confidentiality protocols, whereby confidentiality must be broken to ensure the safety of the participant. These safeguarding concerns will be reported to the relevant professionals and children will be informed in an age-appropriate way what is happening and why.

Another possible risk is that the content of the interviews may evoke some emotional distress for certain participants. To minimise the risk of this, the questions in the interviews and themes in the focus groups will focus on the Kidstime sessions/Who Cares? Project predominantly, and will not involve direct questions about the specific details of mental health problems/parental mental health problems. I do however recognise that such themes may arise indirectly, as a result of these discussions. The researcher is a doctoral trainee educational psychologist with experience and training in dealing with emotional distress, in the unlikely event that this should occur and can signpost the most appropriate support services if necessary, depending on the nature of the issue. For example, mental health services, domestic violence services, family support services, social services. If any participants are emotionally affected by any of the questions, they will be asked if they would like to stop the interview completely, or try again at another time. If participants experience significant distress, the researcher will respond to the participants needs. This may involve spending time

talking with the participant, calming the participant and exploring the support network around the participant to determine whether they have appropriate support to manage their distress. Relevant support services will be signposted as necessary. There are trained therapists, psychologists and family workers present at Kidstime sessions who would also be able to offer support if necessary. The researcher has enhanced DBS clearance through the university.

The interviews and focus groups may include some children with special educational needs (SEN). As the researcher is trained in working with these children, they can be mindful of the child's needs during the interview / focus group and adapt their approach as necessary. The interviews will also include parents with mental health needs of varying degrees. The researcher will therefore use their training and professional judgement to minimise any distress to the research participants. The researcher will ensure that participants are comfortable and willing to continue throughout the interview by occasionally checking, and will terminate the interview at this time if this is not the case.

All participants will be debriefed after the interview in an age-appropriate way to ensure participants feel comfortable with what they have discussed and to remind them of their rights as participants. Participants will be reassured of their anonymity and reminded of the confidentiality agreement as well as their right to withdraw any data. My contact details are at the bottom of the letter originally sent to the participants, but will be given again if needed.

DATA PROTECTION AND STORAGE

Voice data will be recorded on a dictaphone and stored in a locked cabinet. Voice data will only be kept for the purposes of transcription and will be stored on a password protected computer and an encrypted memory stick. This will be backed up on a secure server – University U drive. The audio recordings will be deleted once transcription is completed. Transcriptions will not have any identifiable personal data attached and will be saved on a password protected computer, in a password protected folder as well as on an encrypted memory stick. Transcription documents will be deleted once the research has been completed.

All research will be presented in an anonymised form. In the final write-up of the research, anonymity will be further ensured by using a pseudonym for the local authority with which the research is concerned.

CERTIFICATE OF ETHICAL APPROVAL

Academic Unit: Graduate School of Education

Title of Project: An exploration of the impact of Kidstime and of parental mental health awareness and support in schools

Research Team Member(s): Danielle Ford

Project Contact Point: Df322@exeter.ac.uk

Supervisors: Shirley Larkin, Caroline Gallagher

This project has been approved for the period

From: 09.05.2018

To: 01.09.2019

Ethics Committee approval reference: 201718-135

Signature:

Date: 14.05.2018



(Lise Storm, Chair, SSIS College Ethics Committee)

Appendix K

Letter to parents attending the Kidstime workshops



Danielle Ford (DEdPsychology)

University of Exeter

St Lukes Campus

Heavitree

Exeter

Devon

EX1 2LU

Dear Parents/Carers

My name is Danielle Ford, a trainee educational psychologist from the University of Exeter. I also work with the multi-agency support team (MAST) in Southbridge. I am about to begin some research for my doctoral thesis about the Kidstime workshops that you attend with your child/children and I would really like you to be involved.

The research will explore the experiences of families and staff at Kidstime. I will also seek views of school staff about support more generally for supporting parental mental illness. The aim is to generate ideas for future support for primary schools.

What happens if I take part?

We will have a 30-40 minute, one to one discussion about your experiences of Kidstime. I will have a separate 20-30-minute discussion with your child/children about their experiences. There is also the possibility that I will have a separate discussion with your child/children's teacher about their opinion of the impact of Kidstime on your child/children and about the Kidstime workshops. I will also be speaking to other teachers and school staff in various schools more generally about what support is available for children who experience parental mental illness.

All of the information gathered will be kept confidential and the identity of yourself and your child will not be included in the write-up of my research. In the unlikely event that I am worried about the safety of yourself and your child, I will need to pass this information on to people that can help. Our discussions will be recorded, so they are able to be written up, but will then be deleted. If you decide you would like to take part, but then change your mind, records from our discussions can be destroyed until the point that the information has been anonymised.

The findings from this research will be written up for my doctoral thesis and may be put forward for further publication in an academic journal. No personal information will be included in these publications. This research study has been approved by the University of Exeter ethics committee and complies with the HCPC and BPS Standards of Ethics.

I would really value and appreciate your participation in this research, as I believe it could help improve the support offered to children and families in the future.

If you are happy to be involved please complete the consent slip below and return to me. If you would like more information about this research, please feel free to ask. You can also send me an e-mail: Df322@exeter.ac.uk.

Many Thanks,

Danielle Ford

Consent Slip



Please return this consent slip if you would like to be involved in the research explained above. If you would like your child to also be involved, please fill in both sections of the consent slip below. The child's permission will also be asked for, once your permission has been given.

I _____ consent to participate in the above research relating to **my** participation in the Kidstime workshops as outlined in the letter received.

Signed:

I consent for my child/children _____ to participate in the above research relating to **their** participation in the Kidstime workshops as outlined in the letter received.

Signed:

Appendix L

Table to show overarching global themes derived from the themes relating to the sets of phase 1 interviews (parents, children and facilitator groups)

‘C’ subthemes refer to themes derived from children’s group, ‘P’ subthemes refer to those resulting from the parent group and ‘F’ subthemes refer to those derived resulting from the facilitator group.

Global Theme	Group themes
G1 – Aims and Impact	C1 Theme: positive impact of Kidstime on parents
	C2 Theme: positive impact of KT on children
	P1 Theme: Positive Benefits to Adults
	P2 Theme: Positive Benefits to Child
	P3 Theme: Adult Expectations of Kidstime
	F1 Theme: Perception of Kidstime Aims and implementation
	F2 Theme: Impact on families
G2 - Barriers to support	F4 Theme: Barriers
	P5: Theme: Ongoing difficulties
G3 - Nature of referral context	P4 Theme: Effective referral process
	F3 Referral process
G4 - Need for extended support / future	C3 Theme: Need for extended support
	P5 Theme: Ongoing difficulties
	F5 Future

Appendix M

Letter to parents and consent forms for secondary-school-aged children



Danielle Ford (DEdPsychology)

University of Exeter

St Lukes Campus

Heavitree

Exeter

Devon

EX1 2LU

Dear Parents/Carers,

My name is Danielle Ford, a trainee educational psychologist from the University of Exeter, working with the multi-agency support team (MAST) in Southbridge. I am doing some research about mental health and illness in families and I would really appreciate your child's participation. Part of my research involves exploring the support and education that children receive in school about mental health and illness.

What happens if my child takes part?

Your child will be part of a small discussion group with a few other children in their school, where we will talk about how they are supported at school in relation to their experiences of mental health and illness in their family. I am hoping that the children will come up with some ideas about what they have found most helpful in school, and think about how these ideas might be adapted to suit younger children in primary schools.

The information gathered will be kept confidential and the identity of your child will not be included in the write-up of my research. In the unlikely event that I am worried about the safety of your child, I will need to pass this information on to people that can help. Our discussion will be audio recorded, so it can be written up, but will then be deleted.

What happens if I change my mind?

You can withdraw your child from the discussion group. I will also speak with your child about the research and discussion group before it is arranged, so they can decide if they want to take part.

The findings from this research will be written up for my doctoral thesis, and may be put forward for further publication in an academic journal. No personal information will be included in these publications. This research study has been approved by the University of Exeter ethics committee and complies with the HCPC and BPS Standards of Ethics.

I would really value and appreciate your child's participation in this research, as I believe it could help improve the support offered to children and families in schools in the future.

If you are happy for your child to be involved please complete the consent slip below and return to _____. If you would like more information about this research, please feel free to send me an e-mail: Df322@exeter.ac.uk.

Many Thanks,

Danielle Ford

Consent Slip



Please return this consent slip if you are happy for your child to be involved in the research outlined above. Your child's permission will be sought in addition to this, once parental permission has been given.

I consent for my child _____ to participate in the above research relating to the support and education they receive in school about mental health and illness in families.

Signed:

Appendix N

Consent forms for secondary school children



I _____ agree to take part in a group discussion about the research on the ‘Who Cares?’ project and the help available in school around mental illness. I understand that I can leave the discussion at any point. I am okay with the group discussion being filmed until our discussion has been written up. I am aware of confidentiality and will keep all the information I hear confidential. I understand that if I have any questions about the research after I have taken part, I can ask Mrs *****.

Signed _____

Appendix O

Letter to SENCOs



Danielle Ford

Southbridge

Dear Special Educational Needs Coordinators

Re: Research – Supporting children of parents with mental illness

My name is Danielle Ford, a trainee educational psychologist from the University of Exeter, working with the multi-agency support team (MAST) in Southbridge. I am currently undertaking some research relating to the support available to children of parents with mental illness, with a view to increasing understanding and support in relation to this vulnerable group. Phase one of my research focused on the 'Kidstime' workshops, which is a psychoeducational and support intervention for children and families where the parents have a mental illness. This phase sought to recognise the impact of this intervention on the attendees.

This current phase of my research aims to;

→ **Explore the views of school staff in relation to the needs and experiences of children of parents with mental illness**

→ **Gain their views on mental health education and support in schools**

→ **Explore barriers to support**

I am hoping to speak with school SENCOs to gain information in relation to the above aims. This will take the form of a semi-structured interview, lasting no longer than an hour, at a convenient time and location.

Information given as part of the discussions mentioned above will be treated with the strictest confidence and identities will be anonymised as part of the research process and write-up. In the unlikely event that a safeguarding issue arises, this will be passed on to the relevant professionals, depending on the nature of the safeguarding concern. Discussions will be recorded, so they are able to be written up (in anonymised form). After this has been done, these audio recordings will be deleted. If you decide you would like to participate, but then change your mind, records from any discussions had can be discarded up until the point that the information from these discussions has been anonymised.

Your participation in this research would be very valuable and much appreciated and could help improve the support offered to children and families in the future. If you have any questions about this research, please do not hesitate to contact me using the e-mail address below. If you are happy to participate please complete the consent slip below and return to myself. My e-mail address is Df322@exeter.ac.uk. Alternatively, please send completed consent forms to the address at the top right-hand side of this letter.

Many Thanks,

Danielle Ford

Consent Slip - SENCo



I _____ consent to participate in the research outlined above relating to knowledge, awareness and support available in schools for children of parents with mental illness.

Signed:
